

**IMPORTANT: This is a fixed indemnity policy,  
NOT health insurance**

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

**Looking for comprehensive health insurance?**

- Visit **HealthCare.gov** or call **1-800-318-2596** (TTY:1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

**Questions about this policy?**

- For questions or complaints about this policy contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioner's website (**NAIC.org**) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.



New Enrollment   Change   Open Enrollment   COBRA   Retiree

**Employer/Employee Section**

Enrollment forms must be submitted directly to us unless the group is self-administered. If the group is self-administered, submit enrollment forms to us only if evidence of insurability is required.

|                                                                                      |                                                 |                              |                 |                  |                       |                            |
|--------------------------------------------------------------------------------------|-------------------------------------------------|------------------------------|-----------------|------------------|-----------------------|----------------------------|
| Employer:                                                                            |                                                 | Group Number/Account Number: |                 | Location:        |                       |                            |
| Employee Name - Last:                                                                |                                                 | First:                       | Middle Initial: | Sex:<br>M      F | Date of Birth:        | Date of Hire (Full Time):  |
| Social Security Number:                                                              | Earnings: \$<br>Weekly      Monthly      Annual |                              | Job Title:      |                  |                       | Class:                     |
| Home Address:                                                                        |                                                 | City:                        |                 | State:           |                       | Zip Code:                  |
| Home Phone:                                                                          |                                                 | Work Phone:                  |                 |                  | Cell Phone:           |                            |
| Spouse Name - Last (If Applicant):                                                   |                                                 | First:                       | Middle Initial: | Sex:<br>M      F | Spouse Date of Birth: | Spouse Social Security No: |
| Has the Employee (if applying) used <b>any</b> tobacco products in the last 2 years? |                                                 |                              |                 |                  | Yes                   | No                         |
| Has the Spouse (if applying) used <b>any</b> tobacco products in the last 2 years?   |                                                 |                              |                 |                  | Yes                   | No                         |

**BENEFIT SELECTION - Critical Illness, Accident, Hospital Indemnity**

**COVERAGE SELECTION:** Your non-medical group insurance program may not include all the benefits listed below. **Ask your Employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.**

**Basic Coverage** (Check all that apply) Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.

|          |            |        |                  |            |        |                    |            |        |
|----------|------------|--------|------------------|------------|--------|--------------------|------------|--------|
| Accident |            |        | Critical Illness |            |        | Hospital Indemnity |            |        |
| Spouse   | Child(ren) | Family | Spouse           | Child(ren) | Family | Spouse             | Child(ren) | Family |

**Voluntary Coverage** (Check all that apply)

Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.

|                    | (A) Add, (C) Change,<br>(D) Delete | Total Amount of<br>Coverage Desired | If (C)hange, list<br>Prior Coverage |
|--------------------|------------------------------------|-------------------------------------|-------------------------------------|
| Accident           | Employee                           |                                     |                                     |
| Accident           | Employee + Spouse                  |                                     |                                     |
| Accident           | Employee + Child(ren)              |                                     |                                     |
| Accident           | Family                             |                                     |                                     |
| Hospital Indemnity | Employee                           |                                     |                                     |
| Hospital Indemnity | Employee + Spouse                  |                                     |                                     |
| Hospital Indemnity | Employee + Child(ren)              |                                     |                                     |
| Hospital Indemnity | Family                             |                                     |                                     |
| Critical Illness   | Employee                           |                                     |                                     |
| Critical Illness   | Employee + Spouse                  |                                     |                                     |
| Critical Illness   | Employee + Child(ren)              |                                     |                                     |
| Critical Illness   | Family                             |                                     |                                     |



**BENEFIT SELECTION      VISION**

**ENROLLMENT**

Spouse includes Domestic Partner and Part to a Civil Union as defined in the Certificate.  
(Choose One)

- Employee
- Employee + Spouse
- Employee + Child(ren)
- Family

**POLICY CHANGE**

(Check Reason for Change)

- Married
- Birth / Adoption
- Widowed
- Divorced
- Address Change

**CANCEL COVERAGE**

- Terminated Coverage  
Date:
- Leave / Layoff
- Other  
Date:

**COBRA CONTINUATION PRIVILEGE**

Previously covered with group as:

- Start Date: \_\_\_\_\_
- Projected End Date: \_\_\_\_\_
1. Employee (termination, reduction in hours, other)
  2. Spouse (divorce from Employee, death of Employee)
  3. Dependent (reached age limit, married, no longer a Full Time Student, other)
  4. Spouse & Dependents (divorce from Employee, death of Employee, other)

For the purposes of this Notice, while prohibited by Federal law, Spouse does not included a same-sex Domestic Partner or Party to a Civil Union. Such benefits may be able under state law of provided by the policyholder.

**COVERED SPOUSE AND DEPENDENTS**

Dependent Child(ren) over the age limit, indicate if Full Time Student (FTS) or Handicapped (HDCP)

| First Name | Last Name | Social Security Number | Date of Birth | Relationship | Sex   | Adult Child FTS or HDCP | Name of Accredited School |
|------------|-----------|------------------------|---------------|--------------|-------|-------------------------|---------------------------|
|            |           |                        |               | Spouse       | M   F |                         |                           |
|            |           |                        |               |              | M   F |                         |                           |
|            |           |                        |               |              | M   F |                         |                           |
|            |           |                        |               |              | M   F |                         |                           |
|            |           |                        |               |              | M   F |                         |                           |
|            |           |                        |               |              | M   F |                         |                           |
|            |           |                        |               |              | M   F |                         |                           |

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy (ies) issued to the Employer listed above. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I do not remain actively at work that my coverage may lapse or terminate. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.

**FOR OFFICE USE ONLY**

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

**Waiver of Coverage:**

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the company.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_



**The laws of some states require us to furnish you with the following notice:**

**FOR APPLICATIONS AND CLAIMS:**

**Alabama:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**California:** For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**District of Columbia:** **WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Hawaii:** For your protection, Hawaii law requires you be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**Maryland:** Any person who knowingly or willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**New Mexico:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**Ohio:** Any person who, with intent to defraud or knowingly that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**Oklahoma:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

**Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**Puerto Rico:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation with the penalty of a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**Rhode Island:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Tennessee:** It is a crime to knowingly provide false incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**Washington:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in application for insurance is guilty of a crime and may be subject to fines and confinement in prison.



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The laws of some states require us to furnish you with the following notice:

**FOR CLAIMS ONLY:**

**Alaska:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**Arizona:** For your protection, Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**Arkansas:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**Delaware:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**Idaho:** Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing false, incomplete, or misleading information is guilty of a felony.

**Indiana:** A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

**Minnesota:** A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

**New Hampshire:** Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in NH RSA 638:20.

**New Jersey:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**Texas:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**FOR APPLICATIONS ONLY:**

**New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.