



Healthcare Indemnity Insurance Enrollment Form

Plan Selection	
Select only one plan per form:	
Level 1 <input type="checkbox"/>	Level 3 <input type="checkbox"/>
Level 2 <input type="checkbox"/>	Other <input type="checkbox"/>

Section 1 - Employer Information

Employer/Group Name: _____ Group Number: _____
 Location: _____ Division: _____

Section 2 - Employee

Employee/Member Name: _____ SSN: ____ - ____ - ____ Gender: M F
 Birth Date: ____/____/____ Are you actively at work?* Y N Date of Hire: ____/____/____
 Mailing Address: _____
 City: _____ State: _____ Zip Code: _____
 Email Address: _____ @ _____
 Phone: _____

Coverage Level	Premium
<input type="checkbox"/> EE only	\$ _____
<input type="checkbox"/> EE + spouse	
<input type="checkbox"/> EE + children	
<input type="checkbox"/> Family	

Pay Mode
 Weekly
 Bi-Weekly
 Semi Monthly
 Monthly

* Actively at Work means you are able to work and perform your normal activities.

Section 3 - Spouse Information

Spouse's Name: _____ Gender: M F Birth Date: ____/____/____

Section 4 - Child(ren) Information (ages 14 days - 25 years) . If additional space is needed, please attach a separate 8 1/2 x 11 sheet of paper.

<p>Child 1 Name (First, MI, Last): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Social Security #: _____ Birth Date: ____/____/____</p>	<p>Child 2 Name (First, MI, Last): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Social Security #: _____ Birth Date: ____/____/____</p>
<p>Child 3 Name (First, MI, Last): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Social Security #: _____ Birth Date: ____/____/____</p>	<p>Child 4 Name (First, MI, Last): _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Social Security #: _____ Birth Date: ____/____/____</p>

Section 5 - Conditions Relating to this Enrollment Form

Agreement: I, as employee, represent that all statements and answers in this enrollment form are complete, true and correctly recorded **TO THE BEST OF MY KNOWLEDGE AND BELIEF** and are made as a consideration for Healthcare Indemnity insurance. I understand that until this enrollment form is approved by National Guardian Life Insurance Company ("NGL"), the underwriter, and 5Star Life Insurance Company ("5Star Life"), the administrator, insurance applied for will not become effective. If within 60 days of receipt of all required documentation this enrollment form is not approved, it will become void and all premiums paid will be refunded; I will be so notified. **Authorization:** I understand this information will be used to determine my eligibility for insurance and that I may revoke this authorization and enrollment form at any time by providing written notice. A photocopy of this authorization shall be as valid as the original. As Employee, my signature authorizes payroll deduction of premiums from my employer for myself and my family members. **NOTE:** 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.

Sign Here
 Employee: _____
 Signed at City: _____ State: _____
 Date: ____/____/____

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