Healthcare Indemnity Insurance
Enrollment Form

Plan Selection
Select only one plan per form:
Level 1 ☐ Level 3 ☐
Level 2 ☐ Other ☐

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: ______________________

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

Pay Mode
☐ Weekly
☐ Bi-Weekly
☐ Semi Monthly
☐ Monthly

Coverage Level
☐ EE only
☐ EE + spouse
☐ EE + children
☐ Family

Premium
$ ____________

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.

Child 1
Name (First, MI, Last): ______________________
Gender: ☐M ☐F Social Security #: ________ Birth Date: ___/___/___

Child 2
Name (First, MI, Last): ______________________
Gender: ☐M ☐F Social Security #: ________ Birth Date: ___/___/___

Child 3
Name (First, MI, Last): ______________________
Gender: ☐M ☐F Social Security #: ________ Birth Date: ___/___/___

Child 4
Name (First, MI, Last): ______________________
Gender: ☐M ☐F Social Security #: ________ Birth Date: ___/___/___

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 civil fines and criminal penalties.

Sign Here

Employee: ______________________

Signed at City: ______________________ State: ________

Date : ____/____/____