



# 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><b>Child 1</b>          Name (First, MI, Last): _____          Gender: <input type="checkbox"/> M <input type="checkbox"/> F Social Security #: _____ Birth Date: ____ / ____ / ____</p>	<p><b>Child 2</b>          Name (First, MI, Last): _____          Gender: <input type="checkbox"/> M <input type="checkbox"/> F Social Security #: _____ Birth Date: ____ / ____ / ____</p>
<p><b>Child 3</b>          Name (First, MI, Last): _____          Gender: <input type="checkbox"/> M <input type="checkbox"/> F Social Security #: _____ Birth Date: ____ / ____ / ____</p>	<p><b>Child 4</b>          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 and with the intent to injure, defraud, or deceive an insurer files a statement of claim of an application containing any false, incomplete, or misleading information may be guilty of a crime and may be subject to fines and confinement to prison.

**Sign Here**

Employee: \_\_\_\_\_  
 Signed at City: \_\_\_\_\_ State: \_\_\_\_\_  
 Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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