



Accident 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 Information

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: _____

Accident Coverage	Premium
<input type="checkbox"/> EE only	\$ _____
<input type="checkbox"/> EE + spouse	
<input type="checkbox"/> EE + children	
<input type="checkbox"/> Family	
Coverage Options	
<input type="checkbox"/> Accident 24-hour coverage	
<input type="checkbox"/> Off the job only coverage	

Pay Mode

- Weekly
- Bi-Weekly
- Semi Monthly
- Monthly

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

Beneficiary(ies). I designate my beneficiary(ies) to receive benefits as indicated below:

Primary: _____ Relationship: _____ Age: ____ Social Security #: _____ Birth Date: ____/____/____
 Contingent: _____ Relationship: _____ Age: ____ Social Security #: _____ Birth Date: ____/____/____

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

Sign Here

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