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: ______________________

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

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

Premium
$ ___________

* 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.

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

Sign Here

Employee: ______________________

Signed at City: ______________________ State: __________

Date : ____/____/____

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