THE HARTFORD

UNION PLUS
HOSPITAL INDEMNITY INSURANCE PLAN
ENROLLMENT FORM

One Hartford Plaza, Hartford, CT 06155 (A stock insurance company)

UNIONPLUS

Name:_____

Address:_____

City/State/Zip:_____

International Union:_____

Local Union Number:_____

☑ **YES,** enroll me in the Union Plus Hospital Indemnity Insurance Plan. I understand I have 30 days to review my Certificate of Insurance at no risk. Please print. Use dark ink. Do not erase. Initial all changes.

Complete and Return to:
Union Plus Insurance Program
P.O. Box 47060
Phoenix, AZ 85068-9963

Policy # AGP-40000 and AGP-40001

1 Enter member information *(Please complete all information)*

Member Name: (FIRST, M.I., LAST) Member Date of Birth: MONTH – DAY – YEAR

Address: STREET

City, State, Zip: CITY STATE ZIP CODE

Phone Number: ( ) – Email Address: Sex: ◯ Male ◯ Female

(Internal use only — for important updates and member bulletins.)

Member SSN: – – Member Occupation:

SPOUSE/DOMESTIC PARTNER *(complete only if enrolling)*

Name: (FIRST, M.I., LAST) Date of Birth: MONTH – DAY – YEAR

Email Address: Sex: Male ◯ Female ◯

(Internal use only — for important updates and member bulletins.)

DEPENDENT INFORMATION *(complete only if enrolling — if more than 4 child(ren), attach additional sheet)*

Name: (FIRST, M.I., LAST) Date of Birth: MONTH – DAY – YEAR

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2 Choose your coverage level

Please refer to the charts on the website for coverage details in order to make your selection and determine today's payment due.

Check one: ◯ Low coverage ◯ Medium coverage ◯ High coverage

Check one: ◯ Age 64 and under ◯ Age 65 and older

Your payment enclosed: $

Please make check payable to AFL-CIO Mutual Benefit Trust.

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Please complete and sign Page 2 of this form before mailing.

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3 Please read, sign, and date

Age Reduction
The Benefit Amount(s) Payable for each Covered Person will decrease by 50% on the Premium Due Date or next day following the date you attain age 80.

Confirmation
I hereby confirm my enrollment in the Union Plus Hospital Indemnity Insurance Plan. Please process my enrollment form and send my Certificate of Insurance immediately. I understand I must be a union member to be eligible for coverage. I hereby certify that the above statements are complete and true to the best of my knowledge. I understand that this Hospital Indemnity Plan will not cover pre-existing conditions (conditions for which I received medical advice or treatment within 12 months) until the coverage has been in effect for 12 months. I understand the above coverage will become effective on the first day of the month following receipt of my enrollment form and first premium payment. I further understand that new conditions will be covered immediately.

I hereby attest that I have major medical health insurance or Medicare that meets the requirements of minimum essential coverage as defined by the Affordable Care Act.

Payment
Automatic bank withdrawal (electronic funds transfer):

Name: (FIRST, M.I., LAST)

Banking institution:

Routing number: Account number:

Bank account type: ◯ Checking ◯ Savings

I authorize the Administrator to initiate debit entries for my regular payment from the bank account provided above. I understand that my payment will be processed on or after the due date and will continue to be deducted from my account unless I notify the Administrator otherwise in writing or my coverage ends. I also understand if corrections of the debit are necessary, this may involve an adjustment to my account.

X **Union Member's Signature** (REQUIRED)

Today's Date MONTH - DAY - YEAR

X **Spouse's/Domestic Partner's Signature** (If applying)

Today's Date MONTH - DAY - YEAR

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE). MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Coverage will be issued upon receipt of this form and will begin when your first premium is received. "Guaranteed Acceptance" means your acceptance into this plan is guaranteed. However, insurance benefits payable are subject to the policy's Pre-Existing Conditions Limitation. You're covered immediately for ALL new health conditions and any current health conditions you have will be covered fully after 12 months.

Hospital Indemnity Form Series includes GBD-2800, GBD-2900, or state equivalent.

FRAUD NOTICE(S)

For Residents of Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of Kentucky:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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[DEFAULT]

3 Fraud Notice (continued)

For Residents of Louisiana:
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.

For Residents of Maryland:
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New York:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Residents of Ohio:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For Residents of Virginia:
Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or who files a claim containing a false or deceptive statement may have violated state law.

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