Union Plus Hospital Indemnity Insurance Plan

Enrollment form

Fill out and return this enrollment form to: **Union Plus Insurance Services**
PO Box 47060
Phoenix, AZ 85068-9963

☑ **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.

Step 1 | Enter member information

Please complete all information:	Policy Numbers: AGP-40000 and AGP-40001
Member name:	**Home address:**
Union Name:	**Union member number:**
Member's date of birth:	**Member occupation:**
Member's Social Security number:	**Gender:** ❑ Male ❑ Female
Phone Number: ( )	**Email** (Internal use only — for important updates and member bulletins.)

Spouse/partner information *(complete only if enrolling)*

Spouse's/partner's full name	
Spouse's/partner's date of birth	**Gender** ❑ Male ❑ Female

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

Child(ren) name:	Date of birth:	Child(ren) name:	Date of birth:
Child(ren) name:	Date of birth:	Child(ren) name:	Date of birth:

Step 2 | Choose your coverage level

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

Check one box below

❑ **Low coverage**	❑ **Medium coverage**	❑ **High coverage**

Your payment enclosed: $

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

101121 101122 101123
101124 101125 101126

CONTINUED ON PAGE 2
Please complete and sign page 2 of this form before mailing

Template - N46004
UID - 46107

Step 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: ______________________________

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 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.

____
Member Signature Date

____
Spouse/Partner Signature (if enrolling) Date

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 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 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 files a claim containing a false or deceptive statement may have violated state law.

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