

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY
One Hartford Plaza
Hartford, Connecticut 06155
(A stock insurance company)



Hospital Indemnity Insurance Plan Enrollment Form

Member ages 64 or younger
Group Policyholder: Air & Space Forces Association (AFA)
Policy Number: AGP-5955

THIS IS AN EXCEPTED BENEFITS POLICY. IT PROVIDES COVERAGE ONLY FOR THE LIMITED BENEFITS OR SERVICES SPECIFIED IN THE POLICY.

Member Information

Are you a member of the Air & Space Forces Association? Yes No

AFA Membership Number: _____ Military Rank: _____

Member's Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Member's Social Security Number: _____ Member's Date of Birth: _____

Gender: Male Female

Cell Phone Number: _____ Work Phone Number: _____

Email Address: _____

Is Spouse/Partner coverage desired? Yes No

Spouse's/Partner's Full Name (if enrolling): _____

Spouse's/Partner's Date of Birth: _____ Gender: Male Female

Dependent Child(ren) information: _____ If more than 4 children, attach an additional sheet

CHILD(REN) NAME	DATE OF BIRTH
_____	_____
_____	_____
_____	_____
_____	_____

Coverage Information

YES, enroll me in the AFA Hospital Indemnity Insurance Plan. I understand I have 30 days to review my Certificate of Insurance at no risk.

Age Reduction

The benefit amount(s) payable for the Member and the Member's Dependent(s) will decrease by 50% on the Premium Due Date on or next following the date the Member turns age 80. This reduction also applies if the Member or the Member's Dependent(s) becomes covered under the Policy on or after the date the Member attains age 80.

Choose the coverage that is right for you: Low coverage High coverage

I hereby enroll in the following coverage (check all that apply): Member Only Member Plus Spouse/Partner Member Plus Child(ren) Family

Mail your enrollment form to: Group Insurance Administrator, P.O. Box 418131, Kansas City, MO 64141-8131.

Confirmation

I hereby confirm my enrollment in the Association Plan Name. Please process my enrollment form and send my Certificate of Insurance immediately. I understand I must be a member of Association 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, until coverage has been in effect for 12 months, this Plan Name will not cover pre-existing conditions (conditions for which I received medical advice or treatment within 12 months preceding the effective date of coverage. 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.

Member's Signature: _____ Date: _____

Spouse's/Partner's 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.

Payment Method (choose one)

A. **Monthly Automatic Withdrawal:** Checking Account (include VOIDED check) Savings Account (include Deposit slip)

I authorize my bank to deduct my insurance premium from the financial account indicated above on a monthly basis. If I wish to discontinue this authorization, or my account number changes, I will notify the plan administrator in writing.

Signature: (as it appears on account) X _____

B. **Credit Card Billing:** Monthly Quarterly Semiannually Annually

MasterCard VISA Card Number: _____ Expiration Date: ____/____/____
MM YY

Print Name: (as it appears on card) _____

I authorize charges against this credit card for the purpose of collecting insurance premium payments due under this plan. If I wish to discontinue this authorization, or my credit card changes, I will notify the plan administrator in writing.

Signature: _____

C. **Direct Bill:** Monthly Quarterly Semiannually Annually

Fraud Notices

For Residents of Alabama:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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.

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 Ohio:

Any person who, with intent to defraud or knowing that he or she 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 Vermont:

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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.