



ACE American Insurance Company
Philadelphia, PA 19106

**Limited Accident & Sickness
Insurance plans designed for
co-employees of
HR Outsourcing**

Mail or fax completed form to:

Towers Affinity Benefit Services
4510 Cox Road, Ste. 111
Glen Allen, VA 23060
Fax: (804) 273-9989

Enrollment Form for Group Insurance

Client's Name: _____

Your Last Name First Name Middle Initial Social Security No.

Your Street Address City State Zip Code

Home Phone Date of Birth Your Email Address

Location of Employment Date of Employment

Sex:

- Male
 Female

Marital Status:

- Single Married
 Divorced Widowed
 Legally Separated

Is this:

- New Coverage
 Change in Coverage

Plan Option Chosen:

- Standard Plan
 Enhanced Plan
 Dental Option

Coverage Type:

- Employee Only
 Employee & Spouse
 Employee & Child(ren)
 Employee & Family

Do you have an eligible spouse? Yes No How many eligible children do you have? _____

Provide the following information for all eligible dependents to be insured under the plan:

_____ Spouse's Full Name	_____ Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	_____ Age	_____ Social Security No.	If age 19-25, is child a full-time college student?
_____ Child's Full Name	_____ Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	_____ Age	_____ Social Security No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Child's Full Name	_____ Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	_____ Age	_____ Social Security No.	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Child's Full Name	_____ Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	_____ Age	_____ Social Security No.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Beneficiary for Accidental Death & Dismemberment Benefit:

Your Beneficiary: _____ Relationship: _____

You will be the beneficiary for Dependents.

Refusal of Coverage (check the box below if you are not enrolling in the plan; you do not need to sign/date the form):

I choose not to enroll in the Limited Accident & Sickness Insurance Plan offered by my employer. I understand that, if at a later date, I wish to enroll in this plan, I will not be able to do so unless there is another open enrollment period.

I have read the Limited Accident & Sickness Insurance Plan enrollment material and accept the terms and conditions of the coverage outlined in it. I understand the Limited Accident & Sickness Insurance Plan does not provide Major Medical or Comprehensive Medical coverage. I have read the enrollment material and understand my coverage is subject to the terms and conditions of the policy issued to my employer. I understand my coverage will go into effect on the date stated in the material only if I am in active service with my employer on that date. If I am not in active service on that date, my coverage will go into effect on the date I return to active service. If I have elected coverage for my dependents, their coverage will not go into effect prior to my effective date. I understand benefits are not payable for pregnancy or child birth unless conception occurs after the effective date of coverage.

I authorize my employer to deduct the required premium for the plan I have elected from my pay.

To the best of my knowledge and belief, all information I have provided is true and complete. I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, the Insurance Company will ask me for written authorization to disclosed information about me.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Employee's Signature

Date Signed