ACE American Insurance Company
Philadelphia, PA 19106

Limited Accident & Sickness Insurance plans designed for CalvertCare Employer Clients

***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

Employer – Please complete this section:

Requested Effective Date: ____________________

Date of Hire: ______________________________

Indicate one of the following:
- ❑ Initial Enrollment
- ❑ Open Enrollment
- ❑ New Hire
- ❑ Life Status Change

Is this:
- ❑ New Coverage
- ❑ Change in

Employer'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

Sex:
- ❑ Male
- ❑ Female

Marital Status:
- ❑ Single ❑ Married
- ❑ Divorced ❑ Widowed
- ❑ Legally Separated

Plan Option Chosen:
- ❑ Value Plan
- ❑ Standard Plan
- ❑ Enhanced Plan

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:

Name	Date of Birth	Sex	Age	Social Security No.	If age 19-25, is child a full-time college student?
Spouse's Full Name	Date of Birth	❑ M ❑ F	Age	Social Security No.	
Child's Full Name	Date of Birth	❑ M ❑ F	Age	Social Security No.	❑ Yes ❑ No
Child's Full Name	Date of Birth	❑ M ❑ F	Age	Social Security No.	❑ Yes ❑ No
Child's Full Name	Date of Birth	❑ M ❑ F	Age	Social Security No.	❑ Yes ❑ No

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 or a life status event.

(Continued on Reverse Side)

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 that hospital and surgery benefits available under the plan may not be payable for any pre-existing condition until after coverage has been in effect for six months.

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