|  |
| --- |
| **Circle the plans you are interested in** B Weekly Rates |
| **X** | **Short Term Disability*** Pays up to 2/3 salary
* Begins 1st day of an accident
* Begins 8th day of an illness
 | Based on income and must work an average of 20-plus hours per week - see agent for rates |
| **X** | **Accident Advantage (Option 4 benefits)*** Accidental emergency treatment $120-200
* Accident follow treatment $40/visit up to 6
* Accident hospital confinement $1500 first 18 hours
* Accident daily hospital benefit $300/day
* Home modification $4,000
* Physical therapy accident $40 up to 10 per
* Accidental death benefit $62,500-250,000
* Wellness benefit $60
 |

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| --- | --- |
|  | **Ages 18-75** |
| **Options** | 1 | 2 | 3 | 4 |
| **Individual****Rider****Total** | $2.97 .99$3.96 | $4.14 .99$5.13 | $5.37 .99$6.36 | $6.18 .99$7.17 |
| **1 parent****Rider****Total** | $5.041.11$6.15 | $7.471.11$8.58 | $9.33 1.11$10.44 | $10.74 1.11$11.85 |
| **Insured & spouse** **Rider****Total**  | $4.56$1.38$5.94 | $6.42$1.38$7.80 | $8.25$1.38$9.63 | $9.48$1.38$10.86 |
| **2-parent Rider****Total**  | $6.30$1.56$7.86 | $9.96$1.56$11.52 | $12.51$1.56$14.07 | $14.40$1.56$15.96 |

 |
| **X** | **Hospital Confinement Choice*** Hospital confinement $1,000 (1/yr)
* Daily hospital confinement $100/day
* Hospital short stay $100 (2/yr)
* **Extended Benefit Rider**
* Physician visit $25
* Medical diagnostic $150
* Ambulance $200-2000
* **Hospital Stay and Surgical Care Rider**
* Surgical $50-1,000
* Daily Hospital confinement $100/day,x365
 |

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| --- | --- | --- | --- | --- |
|  | **Prem** | **EBR** | **HSSCR** | **Total** |
| **Ind 18-49****50-59****60-75** | $6.24 $6.36$6.54 | $2.70$3.06$3.09 | $4.26$5.46$7.11 | $13.20$14.88$16.74 |
| **1 par 18-49****50-59****60-75** | $8.85$9.36$10.02 | $5.67$6.36$6.42 | $7.80$10.83$13.56 | $22.32$26.55$30.00 |
| **Ins/SP 18-49****50-59****60-75** | $7.92$8.04$8.19 | $5.37$5.49$5.61 | $5.88$6.69$8.79 | $19.17$20.22$22.59 |
| **2-par 18-49****50-59****60-75** | $9.39$9.48$10.14 | $6.87$6.99$7.29 | $7.92$11.19$14.49 | $24.18$27.66$31.92 |

Prem = Base premium for Option 1EBR = Extended benefit riderHSSCR = Hospital Stay and Surgical Care Rider |
| **X** | **Cancer Care Classic Benefits**Initial diagnosis $4,000/8,000Chemotherapy up to $600/weekRadiation up to $350/weekHospitalization $200-400/daySurgical prosthesis up to $2,000Family lodging $65/day |

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|  | **Ages 18-75** |
|  | **Prem** | **IDR** | **SDR** | **RPrem** | **Total** |
| **Individual** | $8.79  | $.30 | $.21 | $4.65 | $13.95 |
| **Insured/sp**  | $14.94 | $.66 | $.39 | $8.00 | $23.98 |
| **1 par fam** | $8.79 | $.30 | $.21 | $4.65 | $13.95 |
| **2-par fam** | $14.94 | $.66 | $.39 | $8.00 | $23.98 |
| Add Dependent child rider at zero cost for individuals and insured & spouse and $.21 for 1 and 2 parent family. |

 |
| **X** | **Critical Care** 3 – covers coma, paralysis, heart attack, organ transplant, stroke, end-stage renal failure, major 3rd degree burns* Initial diagnosis $7,500/10,000
* Reoccurrence $3,500
* Hospital confinement $350/day
* Specified heart surgery $2-4,000
* Continuing care $125/day
* Ambulance $250-2,000
* ICU up to 2 weeks $800-1,300
 |

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| --- | --- | --- | --- | --- |
| **Age** | **18-35** | **36-45** | **46-55** | **56-70** |
| **Individual** | $3.90  | $5.52 | $8.16 | $11.28 |
| **Single parent** | $6.63 | $7.83 | $10.08 | $14.22 |
| **Insured & spouse** | $7.50 | $9.93 | $15.27 | $21.78 |
| **2-parent family** | $8.49 | $10.80 | $16.20 | $23.31 |

Add First Occurrence Building Benefit Rider for $.51-$2.52 Add Specified Health Event Recovery rider for $.27 - $2.85 |
| **X** | **Dental**

|  |  |  |  |
| --- | --- | --- | --- |
| **Age 18-70** | **Level 1** | **Level 2** | **Level 3** |
| **Individual** | $6.99 | $8.55 | $12.39 |
| **Single parent** | $13.41 | $16.62 | $24.39 |
| **Insured & spouse** | $13.59 | $16.74 | $24.63 |
| **2-parent family** | $20.28 | $25.02 | $36.63 |

 |
|  **Vision**  |
|  **X** | **Age** | **Individual** | **1 parent** | **Insured/spouse** | **2-parent** |
| **18-39** | $2.49 | $4.11 | $3.93 | $5.19 |
| **40-49** | $3.39 | $4.74 | $5.73 | $6.72 |
| **50-70** | $5.10 | $5.19 | $8.79 | $8.97 |

**Level 1** for immediate coverage ($90 frame/lenses) + $45 exam benefit.
**Level 2** = 12 month waiting period ($220 frame/lenses) + $45 exam benefit.
**Level 3** = 24 month waiting period ($380 frame/lenses) + $45 exam benefit.

**Benefit Enrollment Form**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_**

**Address: ­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_**

**Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ E-mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Job Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hourly Pay or Salary \_\_\_\_\_\_\_\_\_**

**Date of Hire \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SS# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_\_\_\_\_\_\_**

**If covering dependents, please provide the following:**

**Name SS# Date of Birth M/F**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_**

**Beneficiary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contingent Beneficiary: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_**

**If applying for life insurance, please provide the following: State born in \_\_\_\_**

**Driver’s license # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_**

**Please initial and date the box that applies to you:**

|  |  |  |  |
| --- | --- | --- | --- |
| ***I am interested in medical coverage*** *and would like to enroll.*Initials \_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_ | ***I am interested in supplemental coverage****.*Initials \_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_ | ***I currently have medical coverage*** *and would like to add supplements.*Initials \_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_ | *I* ***am not interested*** *in either major medical or supplements at this time.*Initials \_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_ |