|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Circle the plans you are interested in** D 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 | | | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | **Ages 18-75** | | | | | **Options** | 1 | 2 | 3 | 4 | | **Individual**  **Ac D Rider**  **Total** | $3.30  .99  $4.29 | $4.59  .99  $5.58 | $6.24  .99  $7.23 | $7.17  $0.99  $8.16 | | **Insured/Sp**  **Ac D Rider**  **Total** | $4.56  $1.38  $5.97 | $7.08  $1.38  $8.46 | $9.09  $1.38  $10.47 | $10.44  $1.38  $11.82 | | **1 par fam**  **Ac D Rider**  **Total** | $5.07  $1.11  $6.18 | $7.83  $1.11  $8.94 | $11.67  $1.11  $11.25 | $11.67  $1.11  $12.78 | | **2-par fam Ac D Rider**  **Total** | $6.83  $1.56  $7.89 | $10.50  $1.56  $12.06 | $13.74  $1.56  $15.30 | $15.81  $1.56  $17.37 | |  | | | | | | | |
| **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 | | | | |  |  |  |  |  | | --- | --- | --- | --- | --- | |  | **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 1  EBR = Extended benefit rider  HSSCR = Hospital Stay and Surgical Care Rider | | |
| **X** | **Cancer Care Classic Benefits**  Initial diagnosis $4,000/8,000  Chemotherapy up to $600/week  Radiation up to $350/week  Hospitalization $200-400/day  Surgical prosthesis up to $2,000  Family lodging $65/day | | | | |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | |  | **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 wks $800-1,300 | | | | |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Age** | **18-35** | **36-45** | **46-55** | **56-70** | | **Individual** | $3.90 | $5.52 | $8.16 | $11.28 | | **1 par fam** | $6.63 | $7.83 | $10.08 | $14.22 | | **Insured/sp** | $7.50 | $9.93 | $15.27 | $21.78 | | **2-par fam** | $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 | | **1 parent family** | $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 par fam** | | **Insured/spouse** | **2-parent fam** |
| **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 ($98 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:**

**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 \_\_\_\_\_\_\_\_\_ |