



Voluntary Accident & Illness Benefits Enrollment Form

Employer Name: _____ Pending Paperwork Number: _____

Contact your benefits administrator for eligibility and available options. Employer Group Number: _____ Division Name: _____

ENROLLMENT REASON

Enroll Change Terminate Other Reason: _____

EMPLOYEE INFORMATION

Employee Name		Date of Hire/Rehire/Retirement	Part- to Full-time Employment Date	Effective Date
Street Address	Apt #	Email	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	# of Hours worked per week: _____ Are you: <input type="checkbox"/> Actively at work <input type="checkbox"/> COBRA <input type="checkbox"/> Retired
City, State, ZIP		Home Telephone	Work Telephone	Do you or any dependents have Medicare? Part A ___ Part B ___ Both ___

LIST YOURSELF AND ALL ELIGIBLE DEPENDENTS AND INDICATE ELECTIONS AT RIGHT. (Note that dependent coverage ends at age 26.)

Name (Last Name, First Name, Middle Initial)	Gender	Birth date MM/DD/YY	Social Security #	Critical Illness	Accident	Hospital Indemnity
Employee	<input type="checkbox"/> M <input type="checkbox"/> F					
Spouse <small>Includes civil unions and domestic partners*</small>	<input type="checkbox"/> M <input type="checkbox"/> F					
Child	<input type="checkbox"/> M <input type="checkbox"/> F					
Child	<input type="checkbox"/> M <input type="checkbox"/> F					
Child	<input type="checkbox"/> M <input type="checkbox"/> F					
Child	<input type="checkbox"/> M <input type="checkbox"/> F					

VOLUNTARY ACCIDENT & ILLNESS BENEFITS (Note that dependent coverage ends at age 26.)

Critical Illness Insurance <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Waive Beneficiary _____ Relationship _____ Date _____	Accident Insurance <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Waive Beneficiary _____ Relationship _____ Date _____	Hospital Indemnity Insurance <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Waive Beneficiary _____ Relationship _____ Date _____
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This is the only record of your beneficiary designation. Please retain a copy and give a copy to your employer to submit at the time of request for death benefits.

AUTHORIZATION AND ACCEPTANCE

I hereby apply for the health plan and benefit plan selected, understanding all benefits and coverage as specified in the enrollment brochure and agreeing to abide by all the rules and regulations therein specified. I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage. The information provided is true and correct to the best of my knowledge. I understand my coverage and benefits may be affected by failure to provide complete and accurate information.

Important: The employee's signature is required before submitting this application. CBIA Service Corp. reserves the right to deny or delay enrollment if information or required signatures are missing from this enrollment form.

Employee Signature _____ Date _____

Employer Signature _____ Date _____

ENROLLMENT INSTRUCTIONS

- Check with your employer for available benefit options.
- Complete all items to avoid delays in processing.
- Please complete all sections including date of birth and Social Security Number.
- Your signature and date and your employer's signature and date must be on the form.
- Covered dependents are eligible to age 26.
- An affidavit may be required at time of claim to verify domestic partner relationship. See cbia.com for a copy of the affidavit.