

# Accident Insurance Pre Enrollment Information Form

## Personal Information:

Name: \_\_\_\_\_ SS# \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Address: \_\_\_\_\_ Contact # \_\_\_\_\_

# Dependents: \_\_\_\_\_ Single or Married: \_\_\_\_\_

DL #: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Email: \_\_\_\_\_ Company: \_\_\_\_\_

Job Title: \_\_\_\_\_ Monthly Income: \_\_\_\_\_

Tabacco User: \_\_\_\_\_ Hours work per week: \_\_\_\_\_

## Dependent Information:

Spouse: \_\_\_\_\_ Male/Female: \_\_\_\_\_ DOB: \_\_\_\_\_

Child 1: \_\_\_\_\_ Male/Female: \_\_\_\_\_ DOB: \_\_\_\_\_

Child 2: \_\_\_\_\_ Male/Female: \_\_\_\_\_ DOB: \_\_\_\_\_

Child 3: \_\_\_\_\_ Male/Female: \_\_\_\_\_ DOB: \_\_\_\_\_

## Beneficiary Information:

Name: \_\_\_\_\_ Male/Female: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ Male/Female: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ Male/Female: \_\_\_\_\_ DOB: \_\_\_\_\_

## Additional Benefit Options:

Check the boxes to add additional benefits and at the bottom, circle the benefit to add to this plan:

<input type="checkbox"/> Income Protector	<u>Just Me</u>	<u>Me &amp; Spouse</u>	<u>Me &amp; Children</u>	<u>Family</u>
<input type="checkbox"/> Critical Illness	<u>Just Me</u>	<u>Me &amp; Spouse</u>	<u>Me &amp; Children</u>	<u>Family</u>
<input type="checkbox"/> Hospital Indemnity	<u>Just Me</u>	<u>Me &amp; Spouse</u>	<u>Me &amp; Children</u>	<u>Family</u>
<input type="checkbox"/> TeleMedicine	<u>Just Me</u>	<u>Me &amp; Spouse</u>	<u>Me &amp; Children</u>	<u>Family</u>
<input type="checkbox"/> Term Life	<u>Just Me</u>	<u>Me &amp; Spouse</u>	<u>Me &amp; Children</u>	<u>Family</u>

# Recurring ACH Payment Authorization

You authorize regularly scheduled charges to your checking/savings account. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your bank statement as an "ACH Debit". You agree that no prior-notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I \_\_\_\_\_ authorize \_\_\_\_\_ to charge my  
(Full Name) (Merchant's Name)

bank account indicated below for \$ \_\_\_\_\_ on the \_\_\_\_\_ of  
(Amount \$) (day)  
each \_\_\_\_\_.  
(week, month, etc.)

This payment is for \_\_\_\_\_.  
(Description of Goods/Services)

## Billing Information

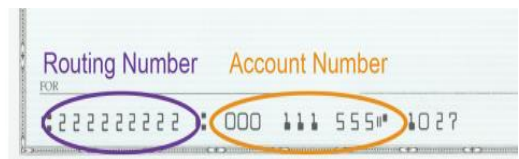
Billing Address \_\_\_\_\_ Phone # \_\_\_\_\_

City, State, Zip \_\_\_\_\_ Email \_\_\_\_\_

## Bank Details

Checking  Savings

Account Name \_\_\_\_\_  
Bank Name \_\_\_\_\_  
Account Number \_\_\_\_\_  
Routing Number \_\_\_\_\_



I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify \_\_\_\_\_ in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that \_\_\_\_\_ may at its discretion attempt to process the charge again within 30 days, and agree to an additional \$ \_\_\_\_\_ charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this bank account and will not dispute these scheduled transactions with my bank; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE \_\_\_\_\_  
(Account Holder's Signature)

DATE \_\_\_\_\_

