

Critical Illness 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 below to add additional benefits and circle one from each row.

<input type="checkbox"/> Accident Insurance	<u>Just Me</u>	<u>Me & Spouse</u>	<u>Me & Children</u>	<u>Family</u>
<input type="checkbox"/> Income Protector	<u>Just Me</u>	<u>Me & Spouse</u>	<u>Me & Children</u>	<u>Family</u>
<input type="checkbox"/> Hospital Indemnity	<u>Just Me</u>	<u>Me & Spouse</u>	<u>Me & Children</u>	<u>Family</u>
<input type="checkbox"/> TeleMedicine	<u>Just Me</u>	<u>Me & Spouse</u>	<u>Me & Children</u>	<u>Family</u>
<input type="checkbox"/> Term Life	<u>Just Me</u>	<u>Me & Spouse</u>	<u>Me & Children</u>	<u>Family</u>

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

