COMBINED INSURANCE COMPANY OF AMERICA
Enrollment form for Group Accident Insurance

Home Office: Chicago, Illinois
FORM # C14059R-MD

(Home Office Use)	Enrollment Date:

I am applying for this coverage based on the following information:

ACTION REQUESTED: ☐ New Certificate ☐ Reinstatement ☐ Conversion ☐ Certificate Change

EMPLOYEE'S (Proposed Insured) NAME (First MI Last)	☐ Male ☐ Female	Birthdate: Mo/Day/Yr	Age
EMPLOYEE'S HOME ADDRESS (Street, City, State, Zip)	Work Phone No.	Social Security No.	Employee ID#
Landline Phone No. / Mobile Phone No.	Email		
EMPLOYER NAME / POLICYHOLDER NAME		Hire Date: Mo/Day/Yr	Gross Annual Income
Occupation			
BENEFICIARY'S Full Name / Relationship	CONTINGENT BENEFICIARY'S Name / Relationship		

Are you actively at work at least 17½ hours each week? Yes ☐ No ☐

COVERAGE FOR: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee, Spouse & Children

List all eligible persons to be covered on this plan: Employee; Spouse; and Your Children age 26 or under.

Name(s)	DOB: Mo/Day/Yr	Relationship	Sex
Employee	(as above)	Self	(as above)
		Spouse	M ☐ F ☐
		Child 1	M ☐ F ☐
		Child 2	M ☐ F ☐
		Child 3	M ☐ F ☐
		Child 4	M ☐ F ☐

Spouse includes a Eligible Domestic Partner/Civil Union Partner who resides with and is financially interdependent with the Applicant, as defined in the Certificate.

Plan: See Certificate Schedule	PREMIUM - Mode
	☐ Weekly (52) ☐ Monthly (12) ☐ Bi-Weekly (26) ☐ Semi-Monthly (24) ☐ _____
Total Premium Per Pay Period:	

It is very important that you review your enrollment form carefully. Misstatements or omissions could cause an otherwise valid claim to be denied. The effective date of approved coverage will be determined as set forth in the certificate of coverage provided to me. **I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application. If coverage cannot be issued as applied for under the rules of the Company, I authorize Combined Insurance Company of America to issue reduced benefits and adjust premiums to match the coverage issued.** I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am applying allows for alternate methods to pay insurance premiums).

In applying for this coverage, I represent and affirm that the information which I have given as recorded on this Enrollment Form is true and complete to the best of my knowledge and belief.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

X _____ City: _____ State: _____ Date: _____
Signature of Employee

I, the authorized agent, have on the date of application recorded the information as given to me by the Employee.
Signature of Licensed Agent _____ Code # _____

REMARKS OR SPECIAL REQUESTS FOR CONVERSION OR POLICY CHANGE