

# FOUNDATION ONE ENROLLMENT INSTRUCTIONS

## **PAGE ONE:**

### Section 1

- Complete this section with your information.
- Date of hire- please list your date of membership with AFTRA

### Section 2

- Please answer questions 1-4.
- An application with these questions left blank will not be considered.
- Question #1- answer "yes" if you are working or are able to work and not disabled.

### Section 3

- Complete this section with any dependents you wish to cover. Leave blank if electing "single" coverage.

### Section 4

- Group Benefit Associates handles premium collection and remittance for this plan so please leave this section blank as it does not apply.

### Section 5

- Be sure to sign and date the application.
- Please list the city and state in the "dated at" section.

## **PAGE THREE:**

### Acknowledgement

Please be sure to sign and date this form. It acknowledges that you have read and understood the American Public Life Summary (HI-4005 IL) of the policy you are applying for. This summary is available online at: <http://groupba.us/FoundationOne/HI-4005 IL.pdf>

## **PAGE FOUR:**

### Premium Payment Agreement

Complete this page with the appropriate billing information for the method of payment you have selected. No application will be accepted without premium payment arrangements.

## **WHEN COMPLETE:**

Fax, mail or email the signed and dated application to:

Group Benefit Associates  
3963 W. Belmont Ave.  
Suite 6  
Chicago, IL 60618

Telephone: 800-450-1271  
Fax: 773-427-6875  
Email: [aftra@groupba.com](mailto:aftra@groupba.com)

Applications must be received by the 20th of the month for coverage to begin on the first of the following month (example, applications must be received by October 20th for coverage to begin on November 1st).

**AFTRA**

**PRD #:** 11181

**Effective Date:** \_\_\_\_\_



# American Public Life Insurance Company

A member of the American Fidelity Group

2305 Lakeland Drive • Jackson, Mississippi 39232  
 Phone: (601) 936-6600 or (800) 256-8606 • Fax: (601) 936-2157

**Subscribing Unit:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

## APPLICATION

**New Enrollment**

**Reinstatement**

**Change of Family Status**

### SECTION 1

### EMPLOYEE INFORMATION

Employee Name:	Date of Birth:	Social Security #:
Home Address:	Date of Hire:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
City, State, Zip:	Home Telephone #:	Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D
AD & D Beneficiary: N/A		Relationship: N/A

### SECTION 2

### COVERAGE INFORMATION

- Are you now actively employed on a regularly scheduled basis?  Yes  No
- Have you or any proposed insured ever had: (1) heart attack; (2) heart bypass; (3) coronary heart disease; (4) a stroke; or (5) internal cancer?  Yes  No
- Have you or any proposed insured ever had or been told that you had Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Antibodies to Human T-Lymphotropic Virus Type III (HTLV-III)?  Yes  No
- Have you or any proposed insured been hospitalized in the last 12 months (for any reason) or been recommended to seek: (1) medical advice; (2) treatment; (3) care; (4) counseling that has not yet been performed? (If none, check here ) If you answered "yes", please give full details:

Name	Date	Type of Injury or Illness	Surgery	Doctor/Address	Other Information

### SECTION 3

### DEPENDENT INFORMATION

(Additional Dependents Attached)

List Full Name of All Dependents To Be Covered under Health and/or Dental Insurance

Name (Last, First, MI)	Social Security No.	Relationship	Date of Birth	Full-Time College Student
				<input type="checkbox"/> Yes <input type="checkbox"/> No Semester Hours: _____
				<input type="checkbox"/> Yes <input type="checkbox"/> No Semester Hours: _____
				<input type="checkbox"/> Yes <input type="checkbox"/> No Semester Hours: _____
				<input type="checkbox"/> Yes <input type="checkbox"/> No Semester Hours: _____

### SECTION 4

### MODE OF PAYMENT

Monthly Premium Amount: \$ \_\_\_\_\_ Cafeteria Plan:  Yes  No  
 Payroll Deduction Period:  Weekly  Bi-Weekly  Monthly  Semi-Monthly  Monthly Bank Draft  Other: \_\_\_\_\_

### SECTION 5

### EMPLOYEE AUTHORIZATION AND SIGNATURE

- I elect to participate in the plan and authorize my employer to deduct from my paycheck any premiums required for the coverage(s) I have selected above.  
 I have been given the opportunity to participate, but I elect NOT TO PARTICIPATE in this plan.

Will Insurance applied for replace or change any insurance in this or any other company?  Yes  No

If "Yes", give Policy #: \_\_\_\_\_ Company Name: \_\_\_\_\_

**I hereby acknowledge receipt of an Outline of Coverage. \_\_\_\_\_ (Please initial)**

I declare that all statements and answers in this application are complete, true and correct to the best of my knowledge and belief and are made as a consideration of the insurance herein applied for. I agree that the insurance issued thereon shall not take effect unless and until a Policy is actually issued and in no event shall the insurance be in force except as provided in the Policy(ies) under which this application is hereby made.

DATED AT: \_\_\_\_\_ APPLICANT: \_\_\_\_\_ DATE: \_\_\_\_\_

AGENT (print): Joel J. Babbitt AGENT (signature): \_\_\_\_\_

In FL, IN, KY, NV, OH and OK: Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim (in FL and KY – or application) containing any false, incomplete, or misleading information (in FL – is guilty of a felony of the third degree.) concerning a material fact is guilty of insurance fraud (in IN, KY, and OK – insurance fraud is a felony) and (in NV – insurance fraud is a Category D Felony). In AR, LA and NM: Any person who knowingly presents false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to (in NM – civil fines and criminal penalties.) fines and confinement in prison (in TN – and denial of insurance benefits).

**HOSPITAL INDEMNITY (Required)**

<b>Benefit Type</b>	<input type="checkbox"/> <b>PLAN A</b>	<input type="checkbox"/> <b>PLAN B</b>	<input type="checkbox"/> <b>PLAN C</b>
Daily Hospital Confinement Benefit	\$200	\$400	\$500
Annual First Occurrence Hospital Confinement Rider	\$200	\$200	\$500
Emergency Accident Rider	\$300	\$300	\$300
Outpatient Sickness Benefit Rider	\$50/\$500	\$50/\$500	\$50/\$500
Intensive Care/Coronary Care Rider	\$600	\$800	\$1,000
Surgery & Anesthesia Rider	\$2,000	\$3,000	\$5,000
Wellness & Diagnostic Test Benefit Rider* <small>*Rider Maximum: The maximum combined benefit payable for all benefits under this rider form is \$250 per person, per calendar year.</small>	Not Covered	Not Covered	\$75/\$250

**If Dependent Child(ren) are in College, give College Name and Address:** \_\_\_\_\_

**Special Requests:** \_\_\_\_\_

**For Agent:** Is Insurance applied for intended to replace or change any insurance in this or any other company?  Yes  No

If "Yes", give Policy #: \_\_\_\_\_ Company Name: \_\_\_\_\_

**Soliciting Agents: (Please Print)**

Joel J. Babbitt

**Agent No.**

346426224

**State Lic. I.D.#**

81-0531212

**Split Percent**

100%

\_\_\_\_\_  
Signature of Agent

\_\_\_\_\_  
Signature of Agent

(If split with other Agents attach on separate sheet)

# American Public Life Insurance Company

2305 Lakeland Dr.

Jackson, MS 39232

## Acknowledgment

Thank you for considering American Public Life in planning for your financial security. We appreciate the opportunity you have given us to present our products to you.

In order for you to make an informed decision regarding application for coverage(s), we have developed a detailed brochure(s) that outlines the provisions of the insurance plan(s). Please read the brochure(s) carefully and ask a company representative any questions you may have regarding information contained in the brochure(s).

Our Company will rely on answers given on your application(s) for coverage(s) in order to determine if coverage(s) can be issued. Moreover, we have the right to rescind coverage(s) or deny claims based on the failure to provide accurate information at the time of application. If you are applying for any coverage(s) that is (are) subject to insurability it may result in additional investigations while the application(s) is (are) being underwritten and at time of any claim. Any underwriting decision will rely upon the cooperation of medical providers and pro-active assistance from you, the applicant, in obtaining medical information needed to determine eligibility for coverage(s).

Please remember some group coverage(s) may require you to be on Active Service on the effective date of your certificate of coverage in order for your coverage(s) to begin. Any health coverage(s) for which you are applying may have wording that may limit benefits for a preexisting medical condition for which you had treatment, took medication, received a diagnosis, or incurred expense. Any health coverage(s) for which you are applying may also have wording that could limit or reduce your benefits.

**PLEASE ACKNOWLEDGE THAT BROCHURE(S) # HI-4005 IL SM (11/04)**

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**HAS (HAVE) BEEN EXPLAINED TO YOU AND THAT YOU HAVE RECEIVED A COPY OF THE BROCHURE(S) BY SIGNING BELOW. A COPY OF THIS FORM WILL BE ENCLOSED WITH YOUR CERTIFICATE AND/OR POLICY.**

Signed \_\_\_\_\_

Date \_\_\_\_\_

\_\_\_\_\_  
Social Security Number

**THIS IS NOT STANDARD DISCLAIMER, PLEASE READ CAREFULLY**

The premiums for this program are collected in advance of the month that they are due. The electronic collection of premium will occur on the 20th of the month prior to the start of the next month. There will be no invoicing of premium; premium will ONLY be collected electronically.

You are authorizing Group Benefit Associates to deduct from a bank account or credit card for the purpose of collecting premiums for the Foundation One policy. All applicants will have their premium processed within 5 business days of enrolling. Final approval in this program is subject to verification of membership and good standing in the AFTRA Union. The act of deducting premium does not constitute coverage.

**All cancellation requests must be received in writing.**

Please Select Payment Method:		
<input type="checkbox"/> Checking Account	Name on account as it appears on check:	
	Bank Name:	
	Routing Number (9 digits):	
	Account Number:	

<input type="checkbox"/> Visa <input type="checkbox"/> MasterCard  <i>**We do not accept Amex or Discover</i>	Name as it appears on card:	
	Credit Card Number:	
	Expiration (MM/YY):	
	Card Security Code (last 3 digits on back of card):	

Signature of premium payer \_\_\_\_\_

Date \_\_\_\_\_

**I hereby authorize Group Benefit Associates to draft my credit card or bank account as listed above on the 20<sup>th</sup> of each month for the purpose of collecting premiums for the AFTRA Foundation One policy I have accepted.**