Empire BlueCross BlueShield — An Anthem Company

THE FEDCAP GROUP — The Power of Possible

The Fedcap Group, Inc.

Group Number: 720419

Enrollment Form

EMPLOYEE INFORMATION. Please verify the information below for accuracy. If incorrect, please contact your HR representative.

Name/Address	**Date of Birth**	**Employee SSN**
	Company	**Date of Hire**
	Effective Date	**Annual Salary**
	Gender	

PLEASE PRINT IN BLACK OR BLUE INK. Read and complete all of this form. Please complete all grayed sections. If you need more space, attach a separate sheet of paper. Please use four digits for years (e.g. 1998, not 98).

Are you actively at work? Yes ☐ No ☐

Are you retired? Yes ☐ No ☐

Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Occupation: _____

Phone: _____

Hours per week working for this employer: _____ **Email Address:** _____

BENEFIT SELECTION. Check the boxes that apply along with the appropriate coverage level.

Voluntary Life

Voluntary Life allows you to expand and enhance your benefits through convenient payroll deduction. Voluntary life gives you the opportunity to purchase life insurance coverage for yourself at a fraction of what insurance would cost in the individual market place. Amounts elected over $200,000 or 3x salary whichever is less will require an evidence of insurability form to be completed.

Accept ☐ **Decline** ☐

You may elect $10,000 increments to a maximum of $1,000,000 or 5x salary,whichever is less. Please select a benefit amount from below or select one from the attached rate matrix.

				Other Benefit
Coverage Amount	☐ **$100,000.00**	☐ **$50,000.00**	☐ **$20,000.00**	☐ _____
Weekly Premium	_____	_____	_____	_____

Reduction Schedule : By 35% at age 65; By 50% at age 70. Benefits terminate at retirement

Voluntary Accident

This coverage provides fixed benefits for specific medical services or events caused or contributed to by an accident.

Accept	Decline	Coverage Level
☐	☐	Employee
☐	☐	Employee + Spouse
☐	☐	Employee + Child(ren)
☐	☐	Employee + Family

Voluntary Specified Disease

This coverage provides lump sum benefits for the occurrence or diagnosis of specific diseases.

Accept	Decline	Coverage Level
☐	☐	Employee
☐	☐	Employee + Spouse
☐	☐	Employee + Child(ren)
☐	☐	Employee + Family

If any person to be covered by a Specified Disease or Hospital Indemnity plan is a resident of CA, GA, NY or CO, please answer the following question:

Will all applicants who reside in CA, GA, NY or CO, when such coverage is to become effective, be enrolled in comprehensive health benefits from an individual or group health insurance policy, an employer sponsored health plan, or an HMO that provides essential health benefits?

(Please note that if the response is No, such applicants are not eligible for coverage) ☐ **Yes** ☐ **No**

Voluntary Hospital Indemnity

This coverage pays a fixed daily benefit for Inpatient Hospitalization caused or contributed to by an accident or sickness.

Accept	Decline	Coverage Level
☐	☐	Employee
☐	☐	Employee + Spouse
☐	☐	Employee + Child(ren)
☐	☐	Employee + Family

If any person to be covered by a Specified Disease or Hospital Indemnity plan is a resident of CA, GA, NY or CO, please answer the following question:

Will all applicants who reside in CA, GA, NY or CO, when such coverage is to become effective, be enrolled in comprehensive health benefits from an individual or group health insurance policy, an employer sponsored health plan, or an HMO that provides essential health benefits?

(Please note that if the response is No, such applicants are not eligible for coverage) ☐ **Yes** ☐ **No**

DEPENDENT DESIGNATION

(Complete all details for Individuals applying for coverage: list names of all dependents.)

Last name, First name, M.I.	SSN (XXX-XX-XXXX)	Sex	Date of Birth (XX-XX-XXXX)	Age	Relationship (spouse/domestic partner or child)
		☐ M ☐ F			Spouse/Domestic Partner
		☐ M ☐ F			Child
		☐ M ☐ F			Child
		☐ M ☐ F			Child
		☐ M ☐ F			Child

List address of all dependents if different from the applicant, including temporary address, e.g. college student.

Name/Address: _____ / _____

Name/Address: _____ / _____

BENEFICIARY DESIGNATION

It is important that your beneficiary designation is clear. It is also important that you name a primary beneficiary and contingent beneficiary. If the beneficiary is not related to you by either blood or marriage, please insert the words 'Not Related' in the relationship box.

NOTE: Please complete the section below for Employee Coverage ONLY. You "the employee" will always be considered the beneficiary for the Dependent Life Insurance when elected.

EMPLOYEE BENEFICIARY DESIGNATION			In equal shares unless otherwise provided below			
Primary Beneficiary	Last name	First name, M.I.	Social Security #	Relationship to Applicant	Age	%
Primary Beneficiary	Last name	First name, M.I.	Social Security #	Relationship to Applicant	Age	%
			In equal shares unless otherwise provided below			
Contingent Beneficiary	Last name	First name, M.I.	Social Security #	Relationship to Applicant	Age	%
Contingent Beneficiary	Last name	First name, M.I.	Social Security #	Relationship to Applicant	Age	%

ELIGIBILITY AND AUTHORIZATION

Employee Confirmation

My signature certifies that I (1) Apply for the coverages designated for which I am eligible under my employer's plan with the carrier. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health to the carrier. (3) Authorize any required deductions from my earnings. (4) Designate the beneficiary named on this application to receive any benefits payable in the event of death. (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature _____ Date _____ / _____ / _____

Premium calculations above may differ slightly based on rounding rules and other system factors, but will not vary significantly. Every effort has been made to match your premiums to the penny.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact materials thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.