

Group Hospital Indemnity Insurance



Member Information

Name _____ Male Female

Address _____

City _____ State _____ Zip Code _____

Social Security Number _____ Birthdate (mm/dd/yyyy) _____

Weight (lbs.) _____ Height (ft./in.) _____

(_____) _____
Phone Email address

Occupation _____

NYSSCPA Member ID Number _____

Spouse Information (if applying)

Name _____ Male Female

Address _____

City _____ State _____ Zip Code _____

Social Security Number _____ Birthdate (mm/dd/yyyy) _____

Weight (lbs.) _____ Height (ft./in.) _____

(_____) _____
Phone Email address

Occupation _____

Dependent Information (if applying)

Name _____ Birthdate (mm/dd/yyyy) _____

Name _____ Birthdate (mm/dd/yyyy) _____

Name _____ Birthdate (mm/dd/yyyy) _____

Daily Benefit Selection

- \$50 \$150
 \$100 \$200*

**Note: \$200 daily benefits are only available to residents in New York Metropolitan area counties of: Bronx, Kings, Nassau, New York, Queens, Richmond, Suffolk, Rockland and West Chester, as defined in NY Statute 52.2 (R).*

Premium Information

- Is this insurance intended to replace or modify any insurance with this or any other company? Yes No
- Are you currently insured under this plan? Yes No
If "Yes," what is your current benefit level? \$ _____
- Payment mode is every six months. Your premium is \$ _____

Billing Selection

Automatic Monthly Withdrawal

By selecting this option, your monthly premium will automatically be withdrawn from your checking account. Please provide the information requested below. **Remember to include a check for your first month's premium and a blank voided check with your application.**

Bank Name: _____

Bank Address: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days' advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer _____

Date _____

Semiannual Direct Bill

Authorization

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact materially thereto, commits a fraudulent insurance act, which may be a crime.

I hereby enroll with The United States Life Insurance Company in the City of New York for coverage under the Hospital Indemnity Insurance Plan. I have read and understand the conditions and exclusions of the program.

I understand that the insurance shall become effective on the first day of the month after receipt and acceptance of my Enrollment Form and first premium payment. If a person is hospitalized on the date insurance is to take effect, such insurance will take effect on the day after the person is discharged.

Member's Signature _____ Date _____

Spouse's Signature _____ Date _____