THE HARTFORD

NASW Assurance Services

HOSPITAL INCOME INSURANCE PLAN

ENROLLMENT FORM

Hartford Life and Accident Insurance Company
Hartford, CT 06155

NASW Assurance Services
Where Social Workers Come First™

Official Member No.:_____

Name:_____

Address:_____

City/State/Zip:_____

Policy # AGP-5730; AGL-5731

1 Please Complete for Member Coverage:

Member Name (First, Middle Initial, Last):

Date of Birth (MM/DD/YYYY): / / Sex: ◯ Male ◯ Female

Address (Street):

Address (City, State, Zip):

Phone Number: ( ) – Email Address:

2 Please Complete for Spouse Coverage (if enrolling):

Spouse Name (First, Middle Initial, Last):

Date of Birth (MM/DD/YYYY): / /

3 Please Select Desired Benefit:

◯ **$80/Day Cash Benefit Plan** ◯ **$160/Day Cash Benefit Plan** ◯ **$240/Day Cash Benefit Plan***
◯ **$320/Day Cash Benefit Plan*** ◯ **$500/Day Cash Benefit Plan***

*Residents of NY are not eligible for this Plan

At age 65, all plan benefits reduce.

4 Please Select Desired Coverage Option:

◯ Member Only
◯ Member and Spouse/Domestic Partner
◯ Member, Spouse/Domestic Partner and Dependent Children
◯ Member and Dependent Children

A spouse or domestic partner must be insured under the same option as the member. Dependent children are eligible for a $15 daily benefit with any option selected by the member.

5 Dependent Children (if enrolling):

If Family coverage is desired, please complete the following:

Name: Date of Birth (MM/DD/YYYY): / /

Name: Date of Birth (MM/DD/YYYY): / /

Name: Date of Birth (MM/DD/YYYY): / /

Name: Date of Birth (MM/DD/YYYY): / /

Please read, sign, and date next page ➡

6 Please read, sign, and date:

I hereby confirm my enrollment in the NASW Assurance Services Hospital Income Insurance Plan. Please process my enrollment form and send my Certificate of Insurance immediately. I understand I must be a member of NASW to be eligible for coverage. I hereby certify that the above statements are complete and true to the best of my knowledge. I understand that this Plan Name will not cover pre_existing conditions (conditions for which I received medical advice or treatment within 12 months until the coverage has been in effect for 12 months . I understand the above coverage will become effective on the first day of the month following receipt of my enrollment form and first premium payment. I further understand that new conditions will be covered immediately. I hereby attest that I have major medical health insurance or Medicare that meets the requirements of minimum essential coverage as defined by the Affordable Care Act.

X _____ __/__/____

Member's Signature (Required) **Date (MM/DD/YYYY)**

X _____ __/__/____

Spouse's Signature (Required if enrolling) **Date (MM/DD/YYYY)**

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

FRAUD NOTICE(S)

For Residents of Florida:
Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For Residents of Kentucky:
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any 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.

For Residents of Louisiana:
Any person who knowingly presents a 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 fines and confinement in prison.

For Residents of Maryland:
Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

For Residents of New Mexico:
Any person who knowingly presents a 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 civil fines and criminal penalties.

For Residents of 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 material 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 such violation.

For Residents of Ohio:
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For Residents of Virginia:
Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or who files a claim containing a false or deceptive statement may have violated state law.

For Residents of Washington:
It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

The Hartford® is The Hartford Financial Services Group, Inc., and its subsidiaries, including issuing company Hartford Life and Accident Insurance Company.

Hospital Indemnity Form Series includes SRP-1151, or state equivalent.

Return completed form today to:
NASW Assurance Services Group Insurance Program Administrators
P.O. Box 26450, Phoenix, AZ 85068-9955
Questions? Call toll-free 1-866-591-8267