NASW Assurance Services

HOSPITAL INDEMNITY INSURANCE PLAN

ENROLLMENT FORM

Hartford Life and Accident Insurance Company
Hartford, CT 06155

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 benefits reduce by 41% and are limited to 52 weeks.

4 Please Select Desired Coverage Option:

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

◯ Member and Spouse/Domestic Partner ◯ 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 →

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6 Please read, sign, and date:

I hereby certify that the above statements are complete and true to the best of my knowledge. I understand that this program will not cover pre-existing conditions (conditions for which I received medical advice or treatment within 12 months of this coverage) until 12 treatment-free months have passed (ending on or after my effective date) or until the coverage has been in effect for 2 years. I attest that I am covered under a health benefits plan, contract or policy (also known as a "primary healthcare plan"), which satisfies minimum essential coverage of 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.

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

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