



NASW Assurance Services
HOSPITAL INCOME 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

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

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 Income 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