

Enrollment Data Gathering Form - Chubb Workplace Benefits



Employer Section			
EMPLOYER NAME City of Hickory			GROUP ID
Effective Date 7/1/2018	Class	Employee ID	Division/Location
Date of Hire	Occupation	Salary	Hours worked per week
Employee Section			
EMPLOYEE'S NAME (First, Last)		Gender	Date of Birth (M/D/Y)
PREFERRED EMAIL		SOCIAL SECURITY #	HOME PHONE #
ADDRESS			

I am actively at work, performing in the usual manner of all of my regular duties at my usual place of employment. (if NO, the employee cannot apply for any coverage listed below)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
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Benefit Elections

Costs shown are based on bi-weekly payroll mode (26 deductions per year)

Accident	<input type="checkbox"/> ENROLL	<input type="checkbox"/> DECLINE					
<input type="checkbox"/> Employee	12.44	<input type="checkbox"/> + Spouse	22.40	<input type="checkbox"/> + Children	25.68	<input type="checkbox"/> + Family	35.64

Critical Illness		<input type="checkbox"/> ENROLL	<input type="checkbox"/> DECLINE		
Have you (or your spouse, if applying for coverage) used tobacco in any form in the last 12 months?			<input type="checkbox"/> YES	<input type="checkbox"/> NO	
Critical Illness EE \$10,000 SP \$5,000 CH \$2,500		Critical Illness EE \$20,000 SP \$10,000 CH \$5,000		Critical Illness EE \$30,000 SP \$15,000 CH \$7,500	
Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker
<input type="checkbox"/> EE	<input type="checkbox"/> EE	<input type="checkbox"/> EE	<input type="checkbox"/> EE	<input type="checkbox"/> EE	<input type="checkbox"/> EE
<input type="checkbox"/> +SP	<input type="checkbox"/> +SP	<input type="checkbox"/> +SP	<input type="checkbox"/> +SP	<input type="checkbox"/> +SP	<input type="checkbox"/> +SP
<input type="checkbox"/> +CH	<input type="checkbox"/> +CH	<input type="checkbox"/> +CH	<input type="checkbox"/> +CH	<input type="checkbox"/> +CH	<input type="checkbox"/> +CH
<input type="checkbox"/> +FAM	<input type="checkbox"/> +FAM	<input type="checkbox"/> +FAM	<input type="checkbox"/> +FAM	<input type="checkbox"/> +FAM	<input type="checkbox"/> +FAM

* You may only select one critical illness option.
 ** The cost shown for SP, CH, and FAM include the cost of EE coverage.



Dependent Enrollment

List all Eligible Persons to be covered by any of the above plans			
Name	Date of Birth (Mo/Day/Year)	Relationship	Gender
		Spouse	<input type="checkbox"/> M <input type="checkbox"/> F
		Child	<input type="checkbox"/> M <input type="checkbox"/> F
		Child	<input type="checkbox"/> M <input type="checkbox"/> F
		Child	<input type="checkbox"/> M <input type="checkbox"/> F
		Child	<input type="checkbox"/> M <input type="checkbox"/> F
Specify more dependents on additional page if necessary			

Beneficiary Designation

BENEFICIARY'S Full Name	Relationship	CONTINGENT BENEFICIARY'S Full Name	Relationship
The Employee will be the Beneficiary of any coverage issued on a Spouse or Child.			

I elect to participate in the benefit plan(s) as indicated above and acknowledge that I am responsible for payment of the above premiums. I further understand that the Critical Illness coverage is not meant to be a substitute or replacement for major medical insurance.

It is very important that you review your enrollment form carefully. Misstatements or omissions could cause an otherwise valid claim to be denied. The effective date of approved coverage will be determined as set forth in the certificate of coverage provided to me. I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application. If coverage cannot be issued as applied for under the rules of the Company, I authorize Combined Insurance Company of America to issue reduced benefits and adjust premiums to match the coverage issued. I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am applying allows for alternate methods to pay insurance premiums).

In applying for this coverage, I represent and affirm that the information which I have given as recorded on this Enrollment Form is true and complete to the best of my knowledge and belief. 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 may commit a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

x	City:	State:	Date:
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