# **PEO Benefits Enrollment Checklist**

Employee Name:				_
Client Name:				_
Benefits Eligibility Date:				
<ul> <li>I am a part-time employee, regularly working for benefits at this time.</li> <li>I am a full-time employee, regularly working the following benefits. I have completed the</li> </ul>	g at least 15 ho	ours per week	Please en	-
	NO Changes	YES Changes	ADD Benefit	DROP Benefit
Cafeteria Section 125 – Flexible Spending Account Cafeteria Section 125 – Dependent Care Assistance Ternian – TermLife TeleMedicine/HealthiestYou Colonial Life – Dental Plan VSP – Vision Plan Life Flight – Critical Care Transport Heritage Health Aflac – PEO Large Group Alfac – Term Life LegalShield Identity Theft Shield  **If ADDING or DROPPING a benefit, you rebenefit for the section of the s		a waiver o	n the app	o o o o o o o o
I understand that if I do not enroll at this time coverage unless I experience a qualifying ev		•	ollment to ele	ect
I understand that if I have not completed a S benefits, my medical, dental, and vision ded on a pre-tax basis.	•	J	٥.	
I understand that a change in family status n dental, and/or vision coverage.	nust occur for I	me to make c	hanges to m	ıy medical,
Signature:		Date:		

(Fill out the appropriate forms attached and turn them in to your supervisor as instructed)

### SAMBEDINO, LLC HEALTH FSA ELECTION FORM

(Please	Print) SONAL DATA	PLAN YEAR		Effe	ective Date	9
				LIIC		<u></u>
	Name			Hoi	me Phone	#
	Address					
	(Stre	et) (Apt.#)	(Ci	ty) (Sta	te)	(Zip)
	Soc. Sec. #	Dc	ate of Birth		Date of	Hire
<b>DEPEN</b> Add	IDENT INFORMATIO	Must List ALL Depo		by Enrolln M/F	nent) SS#	Date of
Chang	€	THIST HATTIE	·	171/1	33π	Birth
<u> </u>	Employee		Self			
<u> </u>	Dependent					
	Dependent					
1	Dependent					
	Dependent					
HEALTH	FLEXIBLE SPENDING AG	CCOUNT   YES   1	NO \$	/Per Pay	<b>/</b> \$	/Annually
3. AUT	HORIZATION AND	ACKNOWLEDGEM	ENT			
	"Status Change". The	annot revoke or change requested election c roke my prior election	hange must be co	onsistent c	and in line wi	th the qualifying
		ust submit a claim anc ) for out-of-pocket Me				
	balance (taking into employment will be p Summary Plan Descri	plan provisions will red account all claims sub provided with informat ption regarding COBR that I will not be reimb tes.	omitted prior to ter ion regarding thei A qualifications). If	mination) COBRA the con	at the time options, if ap tinuation for	of terminating oplicable (see your the Health FSA is
	PayCheck Connection elected above. I und	cipate in a Flexible Spe on, LLC to make preta: lerstand that to stop sung with my request, ar	x deductions from uch deduction, I m	my salary oust notify	on the pay PayCheck (	roll schedule I've
		emaining in your Flexib laims must be incurred bursement.				
SIC NI A	THE			DATE		

# SAMBEDINO, LLC DEPENDENT CARE ASSISTANCE PLAN ELECTION FORM

(Please 1. <b>PER</b> S	Print) SONAL DATA	PLAN YEAR		Fff∈	ctive Dat	·e
1, I LIX	SONAL DAIA	TEAN TEAN		LITO	CIIVO DOI	<u> </u>
	Name			Hor	ne Phone	e#
	Address					
	(Stre	eet) (Apt.#)	(Ci	ty) (Stat	e)	(Zip)
	Soc. Sec. #	Do	ate of Birth		_ Date o	f Hire
	Engail Address					
DEDEN						
Add Chang	Last Name	N (Must List ALL Dep First Name			SS#	Date of Birth
	Dependent					Dilli
	Dependent					
	Dependent					
	Dependent					
	Dependent					
HEALTH	FLEXIBLE SPENDING A	CCOUNT   YES	NO \$	/Per Pay	<b>,</b> \$	/Annually
3. AUT	HORIZATION AND	ACKNOWLEDGEM	ENT			
	"Status Change". The	annot revoke or change requested election of voke my prior election	change must be co	onsistent o	nd in line w	rith the qualifying
		oust submit a claim and Denses before I can be		umentatio	on for out-o	f-pocket
	balance (taking into employment will be   Summary Plan Descr	e plan provisions will re account all claims sul provided with informa iption regarding COBF that I will not be reimbates.	bmitted prior to ter tion regarding thei RA qualifications). It	mination) r COBRA of the cont	at the time options, if a inuation for	of terminating oplicable (see you the DCAP FSA is
	PayCheck Connection elected above. I und	cipate in a Flexible Spo on, LLC to make preto derstand that to stop s ing with my request, a	ax deductions from uch deduction, I m	my salary nust notify	on the pay PayCheck	roll schedule I've
		emaining in your DCAI claims must be incurred nbursement.				
CIC NI A	TUDE			DATE		

### **Enrollment Form for Group Insurance**

**AXIS Global Accident and Health Insurance** 



Step 1: Select Your Enrollment Method (Choose one only.)

1. WEB: http://paycheckconnection.myternian.com 2. PAPER: Turn in the form to your employer

YOUR GROUP NUMBER IS: 8999858

### Search PHCS network providers at: www.myternian.com or call 1-866-750-7427

(You DO NOT need to use these providers – they provide discounts should you choose to visit them. You can visit ANY licensed physician and present your insurance card – you may qualify for a discount. But regardless, you still have insurance coverage as outlined in this brochure.)

Step 2: Select the plan(s) that you want. DETAILS AND PRICING FOR EACH PLAN ON PREVIOUS PAGES.

	Group Term Life  □ \$10,000Plan  □ \$20,000 Plan			
	☐ EE Only☐ EE + Dependent☐ EE + Family			
Step 3: Select who you want to cover. Ch	IECK ONLY ONE EVEN IF MULTIPL	E PLANS ABOVE AI	RE SELECTED.	
☐I want to cover myself only ☐I want	to cover myself and 1 dependent (s	pouse or child)	□I want to cover	r myself and my family
Step 4: Provide the information that we r	need in order to enroll you and/o	your family mem	bers.	
First Name M.I.	Last Name	Gender (N	1/F)	Date of Birth
Social Security Number		Hire Date		
Street Address	City	State		Zip Code
Email Address (REQUIRED for DoctorNavigator login access		Primary Pl	none #	Home Work Cell
<b>DEPENDENT INFORMATION (IF ANY):</b> For	or more than 3 dependents attach a		- Time Student? ☐ Yes ☐	7.No
Spouse/Child First Name M.I.	Last Name	Gender (M/F)		No Birth Date (mm/dd/yyyy)  No
		Full 1	ime Student? Yes	] No
<b>BENEFICIARY INFORMATION:</b> Person who w	Il receive benefits in the case of your de	ath. You will be the bei	neficiary for dependent	ts.
First Name M.I. Last	Name	- Gender (N	1/F)	Relationship to You
WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURE				
Employee's Signature		Date Sign	ed	
<b>Declination Waiver:</b> (check the box below	if you are not enrolling in the plan	YOU ARE STILL RE	QUIRED TO SIGN AN	D DATE THE FORM):

☐ I choose not to enroll in the plans being offered by my employer. I understand that, if at a later date, I wish to enroll in this plan, I will not be able to do so until there is another open enrollment period.

I have read the AXIS Global Accident and Health Insurance Company enrollment brochure, including the exclusions and limitations, and accept the terms and conditions of the coverages outlined in it. I understand the fixed indemnity insurance plans are not considered creditable coverage under HIPAA and do not provide Major Medical or Comprehensive Medical coverage. I have read the enrollment brochure and understand my coverage is subject to the terms and conditions of the policy issued to my employer. I understand my coverage will go into effect on the date stated in the brochure only if I am in active service with my employer on that date. If I am not in active service on that date, my coverage will go into effect on the date I return to active service. If I have elected coverage for my dependents, their coverage will not go into effect prior to my effective date. I authorize my employer to deduct the required premium for the plan I have elected from my pay. If direct billing is offered, I authorize Ternian Insurance Group to charge the required premium for the plan I have elected from my credit or debit card. To the best of my knowledge and belief, all information I have provided is true and complete. I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, the Insurance Company will ask me for written authorization to disclose information about me.



### TeleMedicine Through HealthiestYou



#### 24x7 Access to Doctors



#### Provider Discovery



### Prescription Savings

When you get sick, our doctors are standing by 24x7 waiting to help you. They can diagnose, treat, and often prescribe for an array of medical issues.

Need to search for a nearby doctor, dentist, or other provider? Our radar makes it easy. You can even research your doctor first! Our awesome price comparison engine can save you up to 85% by shopping and comparing a variety of prescriptions to find the best prices nearby.

**HealthiestYou** is changing the way real people access healthcare! For only \$19.95/month.

□ Empl	oyee Only	☐ Employee + Family	
Name	Relationship	Gender	Date of Birth
	Employee		
Address:			
City, State, Zip:		Pho	ne:
Email Address:			
Signature			



Phone: 877.303.7590 Fax: 877.303.7591 PO Box 1510; Hayden, ID 83838

# COLONIAL LIFE & ACCIDENT INSURANCE COMPANY PO BOX 1365, COLUMBIA, SC 29202

### DENTAL INSURANCE APPLICATION FORM

☐ Reinstatement		ipgrade Iowngrade		□ Dep		tion	1		Existing Policy No	)		
EMPLOYEE SECTION		J										
Proposed Insured Nan		, Last)				Gende M □ F □		irthda	te (mm/dd/yyyy)	5	Social Se	curity No.
Home Address – Stree	et	(	City	State		Zip Co	ode			•		
Email Address									Home Phone N Business Phone			
Date Employed	Hrs. Worke	d/Wk	Section/De	pt. No.	Job	Title					Employe	ee ID/Payroll No.
Employer Name Sambedino, Inc		<u>.</u>							t-City-State-Zip) Coeur d'Alene, I	D 838	15	
SPOUSE/DEPENDEN	IT SECTION	(complete if	applying for	spouse a	nd/or d	lepender	nt cover	age)				
	First, MI, Las			nder		ate (mm/			Relationship		Socia	I Security No.
			МП	F□								
			МП	F□								
			МП	F□								
			МП	F□								
			МП	F□								
			МП	F□								
			МП	F□								
ELIGIBILITY SECTIO	N		l	l								
Are you actively work		o" you are not	eligible for a	any cover	age.							Yes □ No □
REPLACEMENT SEC		-	V		· ·							
2a. Will any dental ins							if the c	overa	ge applied for is is	ssued?	lf	
yes, complete required 2b. If replacing existing	g coverage,	please indicat	te if existing	coverage	is Colo	onial Life					er	∕es □ No □
carrier's Dental covera	ige by check	ing the appro	priate box.	<u> </u>	ioniai L	ITE & AC	cident ii	nsura	nce Company	□ Ot	ner	
PLAN SECTION  Type of Coverage	Type of	Level of	Policy	Vicio	n Cove	orago	Orth	20401	ntia Coverage	Tay	Status	Monthly
Type of Coverage	Change	Coverage	Plan Code		t Yes				Yes or No)	<b>(P)</b> pr		Premium
☐ Individual ☐ Individual &		□ Plan 4		No	t Availa	able		Not	Available			
Spouse ☐ Individual & Children		□ Plan 5										
☐ Individual & Family												
OTHER SECTION												
3. Do you have any ex	isting dental	coverage tha	it will remair	n in force?	'If yes,	please p	orovide	comp	pany name.		\	Yes □ No □
4. Are you Medicare e												Yes □ No □
5. Has the Important N	lotice to Per	sons on Medi	care and the	e Guide to	Health	n Insuran	ce for F	People	e with Medicare be	een		Yes □ No □
r brovidea?											ı	

DentApp-ID 82736

AGREEMENT SECTION	
It has been explained and I understand that any coverage approved may be subject to waiting periods, exclusions and limitations as descr	ribed in
the policy.	
I understand that this application will not be binding upon Colonial Life until both: 1) the policy is issued; and 2) the first premium is paid. It	tems 1 and
2 must occur while any conditions affecting insurability are the same as described above. I understand that any untrue statement of	
misrepresentation may result in claim denial or rescission of coverage. If coverage is rescinded, Colonial's only obligation will be to refund all	
paid. I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION N	IÚMBER.
I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effect understand that my payroll deduction amount will change if my coverage or premium changes.	ctive. I also
Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or sta	atement of
claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material theret a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.	
REQUEST FOR TRANSFER/CANCELLATION: In conjunction with my application for the coverage indicated, I hereby request cancella	ation of my
Colonial Life Policy Number(s) Transfer or cancellation of the base plan will also mean cancellation of all attack	hed riders
If for any reason the coverage applied for above is not issued, this request for cancellation shall be null and void.	Ilou iluois.
This policy provides dental and/or vision benefits only. Review your policy and any applicable riders carefully.	
Signed at: City Coeur d'Alene State ID Zip Code 83815 Date mm/dd/yyyy	
mm/dd/yyyy	
(x)Signature of Proposed Insured (if applicable)	
Signature of Proposed Insured (if applicable)	
AGENT SECTION	
Agent's Name (If Present): Carolyn Schultz	
(please print)	
Do you have knowledge or reason to believe that the Proposed Insured is intending to replace any existing dental insurance? Yes $\square$ No	) Ц
I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage(s) applied for, including any pertaining to periods and limitations, if applicable. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not full in this application. I have not made, nor agreed to make, any rebate of premium for insurance. I further certify that I am a licensed agent i state where this application is being taken.	ly set forth

Signature of Licensed Agent

mm/dd/yyyy

DentApp-ID 82736



### VSP Vision Plan Enrollment/Change Form

 $\mathbf{G} \ \mathbf{R} \ \mathbf{O} \ \mathbf{U} \ \mathbf{P} \quad \mathbf{I} \ \mathbf{N} \ \mathbf{S} \ \mathbf{U} \ \mathbf{R} \ \mathbf{A} \ \mathbf{N} \ \mathbf{C} \ \mathbf{E}$ 

Employee Effective Date:

For Sambedino, Inc. Use Only

Date Sent to Payroll Dept.: \_\_\_\_\_

Vision care for life  Date Sent to Benefits Dept.: by:  Date Added to VSP Spreadsheet by:											
SECTI	ON 1: QUAL	IFYING E	/ENT (Please Che	ck One)							
			llment □ Plan 0	·							
	d/Delete Dep		-	date of qualifying event. Then	-	-		/ Other	· ·		
□ Ad	dress/Name	Change/Co	orrection   CO	BRA Continuation ☐ Do N	lot Want Coverage -	- Waive					
			/e://		over D. Other In						
Ke	ason: ⊔	Lett Emplo	yment Li Redu	ced Hours	erage Li Other in	surance					
	ON 2: MEMI Security Numb		RMATION	Date of Birth	Marital ☐ Single		riod	# of Depender	nts Including	Spouse	Gender ☐ Male ☐ Female
Membe	r's Last Name			First		- Ivian	icu	M.I.			I Wale I Telliale
	Address	ahla unlaga r	ural D.O. Bay)			Cit	ty		State		Zip Code
Client N		adie uniess r	ural P.O. Box)	Position/Title/Job Classification	Home Phon	<u> </u>		Date	of Hire (Re	equired)	
					l			ļ			
Add	ON 3: DEPE Change	NDENT IN  Delete	FORMATION Last Nam	e (if different), First, MI	Social Securi	hv #	Pols	ationship to me	mher	M/F	Date of Birth
Auu	Onlange	Delete	(Spouse)	e (ii dinerent), i not, iii	Oociai occuii	<u>υ π</u>	Neit	itionismp to me	ilibei	.,,,,	Date of Birth
			(Child)*								
			(Child)*								
			(Child)*								
			(Child)*								
				tudent, the following documen vith name of institution, studen						od.	
SECTI	ON 4: OTHE	R INSUR	NCE COVERAGE								
	or your spous	e have cove	rage under another g	roup vision insurance plan? 🗖 `Y	YES – Please complet			NO – Please skip Phone Number:	to Section	5.	
	of Policy Holde	ar .					cy Holder's				
	ee Name				Policy Holder's	1 011	cy Holder s		Effective Da	nto.	
Lilipioy					Date of Birth:				of Coverage		
SECTION 5: AUTHORIZATION  I hereby apply for membership with the VSP Vision Plan and authorize my employer/union/group policy holder to deduct from my earnings the necessary contribution, if any is required of me. I hereby authorize any physician, dentist, hospital, or insurer having any records or information concerning health history or other insurance for me, or my minor dependents, to furnish such records, data, or information as may be requested by VPS or their duly authorized representative to review eligibility, determine benefits (if any) and/or process vision claims. I understand that this authorization is valid for a minimum of 12 consecutive months from the date signed. A photocopy of this authorization shall be considered as effective and valid as the original. I understand that I, or any authorized representative may receive upon request, a copy of this authorization  It is the member's responsibility to notify Sambedino, Inc. of any changes of address or family status in writing by completing a new form.											
□ldo	o not want to	participate	in the VSP vision	program. I am waiving covera	age. (Please check t	he box a	and sign b	elow.)			
Emplo	yee/Membe	r Signature		Date Signed	Employer Signature			Compar	ny Name		



There. When You Need Us.®

### **GROUP MEMBERSHIP ENROLLMENT**

### **PayCheck Connection, LLC**

#### **MEMBER ENROLLMENT INFORMATION**

Name:		Date of I	Birth:
Spouse/Domestic Partner:	Date of I	Sirth:	
Mailing Address:			
City:	Ctoto		Zip:
Phone:	Email Address:		
Additional Eligible Household Members Includes any dependents claimed on your		ily members living in t	he same household
		Date of Birth	Relationship
			_
			_
			_
I am an existing member. ID# (i	f known)		
Member's Signature:			

### **GROUP DISCOUNT MEMBERSHIP:**

- ◆ Annual fee of \$75 per year per household.
- Discount rate is valid with enrollment through an approved group only.
- ♦ Payment directly to Life Flight Network is not available.
- Complete Statement of Understanding is found on the reverse side of this form.

#### **LIFE FLIGHT NETWORK FOUNDATION**

P.O. Box 3841 • Portland, Oregon 97208-3841 Phone: (503) 678-4370

This form is valid through 11/30/2020. Contact your employer or group representative for an updated enrollment form if this form is expired. New member benefits take effect 72 hours after receipt of completed enrollment form and payment. Life Flight Network transports patients based on medical need, not membership status. Medicaid beneficiaries should not apply for membership. Life Flight Network operates under its own FAA Part 135 Air Carrier Certificate.

### STATEMENT OF UNDERSTANDING

### By becoming a Life Flight Network Member, you agree to the terms stated below.

A Life Flight Network Membership relieves you from liability for out-of-pocket costs of emergent, medically necessary transports completed and billed by Life Flight Network. Your membership is not an insurance policy but secondary to insurance carriers and health care cost sharing programs. All available insurances will be billed first including health, auto, workers compensation and third-party insurance. Life Flight Network will accept payment from insurance carriers and other third party payers as payment in full.

Membership benefits are available for those eligible household members listed on the member record at the time of transport if the transport is an emergent, medically necessary transport to the closest, most appropriate facility, performed by Life Flight Network, its contracted agents, or reciprocal partners, subject to the reciprocal program's rules.

Membership benefits are extended to the primary member, his/her spouse or domestic partner and dependents claimed on their income tax return. Dependents must be added to the member record within 30 days of birth or adoption. Elderly (age 65+) and disabled family members living in the same household are also covered. Life Flight Network may require documentation or other verification of membership eligibility.



Emergency medical transports are based on medical need, not membership status. Medical need can only be determined by a physician, EMS provider, hospital or another qualified third-party recognized by Medicare, and is in all cases subject to the final determination of the health insurance carrier, if any. Non-emergent transports are not eligible for Life Flight Network membership benefits.

Availability of service cannot be guaranteed due to weather conditions, maintenance, commitment to another transport, out-of-service equipment and other reasons.

New and lapsed membership benefits take effect 72 hours after receipt of a completed enrollment with payment.

Membership fees are non-refundable, non-transferable and are not tax-deductible. Life Flight Network may cease selling and servicing memberships should any governmental body, now or in the future, determine memberships can no longer be offered within their jurisdiction. No refunds will be made for any memberships already purchased.

I transfer directly to Life Flight Network my rights to insurance payments due to me for services provided by Life Flight Network. Such payments shall not exceed Life Flight Network's regular charges. Denial of a claim by an insurance provider must be received by Life Flight Network in writing. Membership benefits do not extend to transports deemed not medically necessary or when insurers deny payments due to coordination of benefit issues. Per government regulations, individuals covered by Medicaid are not eligible for Life Flight Network membership and should not apply.

I specifically release and waive any and all rights, claims or causes of action against Life Flight Network and its employees and agents with respect to my Life Flight Network Membership.

The Membership Program may be canceled at any time for any reason, including financial feasibility and governmental regulation of such programs. Terms and conditions are subject to change. For current terms see <a href="https://www.lifeflight.org">www.lifeflight.org</a>





- I acknowledge and understand that I am voluntarily becoming a patient of Heritage Health Community Health Center and that this agreement is non-transferable.
- I have reviewed the EVERYDAY **Wellness** Patient Services Guide and I have had the opportunity to ask questions and receive answers regarding its content.
- I acknowledge and understand that this agreement does not provide comprehensive health insurance coverage nor is it a contract of insurance.
- I understand that this plan only provides the health care services described in the EVERYDAY Wellness Patient Services
- I acknowledge and understand that I am responsible for any charges incurred for health care services performed outside of this plan including, but not limited to emergency room, hospital and specialty services and that Heritage Health CHC will not bill insurance carriers for services provided to me while on this plan.
- I acknowledge and understand that Heritage Health CHC must maintain a record of my health information.
- I acknowledge and agree to pay my monthly care fee on or before its due date. In the event that I am unable to pay my fee(s) on time, I understand that I will be charged late fees and that my service agreement may be terminated.
- I acknowledge and understand that Heritage Health CHC may terminate this agreement by providing me 10 days written notice and any prepaid care fees will be prorated to the date of termination and refunded to me within (10) ten business days. Heritage Health CHC will not terminate this agreement solely on the basis of health status.
- I acknowledge and understand that Heritage Health CHC may add or discontinue services or may increase my fee schedule at any time, and that I will be given in writing, at least sixty (60) days notice of such fee schedule changes.
- I acknowledge and understand that if I am enrolled in Medicare I will receive a copy of the Medicare Opt-Out Agreement for review and signature before my first appointment.
- I agree that neither myself nor Heritage Health CHC will seek reimbursement for the care that I receive from a third party insurance program.

My signature below indicates that I have read, reviewed and understand the terms and conditions of my membership program with Heritage Health Community Health Center

Print Name:			
Signature:	Date:		
Emp Last Name:	First Name:	MI: Date of Birth:	M F
Social Security Number:	Are you enrolling your	self? 🗌 Yes 🗌 No Dependa	nts 🗌 Yes 🔲 No
Home Address:	City:	State:	Zip:
Billing Address:	City:	State:	Zip:
Phone #1: ( )	☐ Home ☐ Work ☐ Cell Phone #	#2: ( ) 🔲 Ho	me 🗌 Work 🗌 Cell
Email Address:		Allow Ema	ails? 🗌 Yes 📗 No
Employer through which you obt	ain your EDW account: PayCheck Co	nnection LLC Payroll Service	es Group
Emergency Contact:	Phone: (	) Relations	hip:
Enrollee Name:	Date of Birth:	Social Security #:	
Spouse Name:	Date of Birth:	Social Security #:	
Dependent Name:	Date of Birth:	Social Security #:	
Dependent Name:	Date of Birth:	Social Security #:	
Dependent Name:	Date of Birth:	Social Security #:	
Dependent Name:	Date of Birth:	Social Security #:	
Dependent Name:	Date of Birth:	Social Security #:	
	· · · · · · · · · · · · · · · · · · ·	·	·

		FOR HOME OFFICE USE ONLY							
		PLAN PLAN CODE					ID NUMBER		
		Accident							
<b>A40</b>	Cr	Critical Illness							
Affac	Ho	ospital Inder	-						
		ndorsement:							
INSURANCE COMPA	_								
EMPLOYEE APPLICATI	ON								
Please Mail: P.O. Box 84 Columbus, GA 31993		FECTIVE D	ATE:						
800.433.3036					FOR A	GENT USE C	NLY		
		☐ Initial				_			
	6	Enrollment	□ New	Hire	□ Re-	Enrollment	□ New E	ligible	☐ Re-Submission
			Dedu	ction s	tart dat	e			
Applicant Name (First, MI, Last)	<u> </u>			Soc	ial Secu	urity # or ID #		Gende	r Date of Birth
Street Address			City					State	ZIP
Group Policyholder Sambedino Inc. #6216			Class Occu	pation		Location		Date o	f Hire
E-mail address			Hours Work	ed per	Week	Daytime Pho	one No.		
Spouse's Name (if coverage is r	requested)					Spouse's Ge	ender	Spous	e's Date of Birth
Beneficiary Name/Relationship	(estate unless d	esignated otl	nerwise)						
							Appl	icant	Spouse
Are you actively at work?							☐ YES		-
Have you used tobacco prod							☐ YES		☐ YES ☐ NO
LIST ALL ELIGIBLE CHILD				OSING	COVE	RAGE (FR			
Name	Gender	Date of	Birth		Name		Gende	<u> </u>	Date of Birth
GROUP ACCIDENT INSURAN	CE							ı	
□ 24 Hour Plan 70000 □ New 0	Coverage □ Cha	ange in Cove	erage						
□ Applicant □ Applicant & Spo	use   Applican	t & Children	□ Family						
Cost per pay period: Including	g any Riders \$_								
GROUP CRITICAL ILLNESS IN	SURANCE [	Applicant	☐ Applicant	and Sp	ouse				
☐ New Coverage ☐ Change in									
With Cancer: ☑ yes	2010.ug0								
With Health Screening Benefit: I	<b>7</b> 1 ves								
☑Heart Event Rider ☑Progress	-	der ⊠ Speci	fied Disease	Rider F	7 Additio	onal Benefits	Rider		
Applicant Face Amount: \$	2.300000 1110	<u></u>				pay period:			
Spouse Face Amount: \$							\$ \$		
opouso i doc Amount. \$							<u>Ψ</u> \$		
			•			-/-	Ψ		
COMPLETE FOR GROUP	P CRITICAL ILL		EMENT OF I				'E GUARAI	NTEE IS	SUE AMOUNT

Applicant

1	In the past 7 years, have you been treated or diagnosed by a medical professional for A Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	ПΥ	ES 🗆 N	10 I	☐ YES ☐ NO		
2	In the last 7 years, have you been treated for or diagnosed with cancer or any malignan including: carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignan Cancer does not include basal cell or squamous cell carcinoma of the skin.	ОΥ	ES 🗆 N	ıo ı	⊒ YES □ NO		
3	In the past 7 years, have you been treated for, or diagnosed with, any of the following:  a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—i artery disease), diabetes, or any liver disorder; b) Kidney (renal) failure or end stage kidney (renal) disease; c) Organ transplant; d) Emphysema; or e) High blood pressure, resulting in your now taking 3 or more medications for treatmen	ΩY	'ES □ N	10 0	⊐YES □NO		
4	In the past 7 years, have you received any advice, treatment, or consultation for: any distinct the central nervous system, Parkinson's disease, Alzheimer's disease, dementia, senilit organic brain syndrome?		ПΥ	ES 🗆 N	10 1	□ YES □ NO	
5	In the last 2 years, have you had a prolonged state of unconsciousness lasting more that left you with a significant neurological disability?	an 48 hou	rs 🗆 Y	ES 🗆 N	IO I	□ YES □ NO	
6	In the past 7 years, have you received any advice, treatment or consultation for a diagnamyotrophic lateral sclerosis (Lou Gehrig's disease) or multiple sclerosis?	ПΥ	ES 🗆 N	10 I	☐ YES ☐ NO		
GR	OUP HOSPITAL INDEMNITY INSURANCE Plan: 80000 ☐ New Coverage ☐ Change i	n Covera	ge				
	Applicant ☐ Applicant & Spouse ☐ Applicant & Children ☐ Family						
☑ B	ase Plan (check one): ☑ Mid						
⊠Tr	eatment Category (check one): ☑ Mid						
⊠Sι	urgery Category – Inpatient and Outpatient (check one): ☑Mid						
Cos	t Per Pay Period Including any Riders:						
If NO	OT Guaranteed Issue, answer the following questions:						
		Appli	cant	Spo	use	Children	
1	In the last 7 years, have you been treated or diagnosed by a medical professional for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) or ever tested positive for antigens or antibodies to an "AIDS" virus?	□ YES	□ NO	□ YES	□ №	□ YES □ NO	
2	In the last 7 years, have you been treated for or diagnosed with cancer or any malignancy, including: carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or a malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	□ YES	□ №	□ YES	□ NO	□ YES □ NO	
3	In the last 7 years, have you been treated for, or diagnosed with, any of the following:  a) Stroke, heart attack, heart condition, heart trouble (or any abnormality of the heart—including artery disease), diabetes, or any liver disorder; b) Kidney (renal) failure or end stage kidney (renal) disease; c) Organ transplant; d) Emphysema; or e) High blood pressure, resulting in your now taking 3 or more medications for treatment?	□ YES	□NO	□ YES	□ NO	□ YES □ NO	
4	In the last 5 years, have you Have you ever sought advice or treatment for alcohol abuse, been arrested for driving under the influence of or while impaired by alcohol, or been arrested for or used illegal drugs or narcotics?	□ YES	□NO	□ YES	□ NO	□ YES □ NO	

Does this coverage replace or change any existing insurance?
Are you currently covered under, or does this coverage replace, an Aflac individual policy? □ YES □ NO     If yes and if it is the same type of coverage you are applying for on this application, please identify which individual policy(ies) you already have: □ Critical Illness □ Cancer □ Accident □ Hospital Indemnity □ Dental □ Disability
If this coverage will replace any existing Aflac individual policy, please be aware that it may be in your best interest to maintain your individual guaranteed-renewable policy via direct bill.
I have considered all of my existing health insurance coverage with Aflac and believe this additional coverage is appropriate for my insurance needs. I further understand that I can contact Aflac at 1-800-992-3522 regarding my individual policy and for assistance in evaluating the suitability of my insurance coverage.
Coverage will not become effective unless you are actively at work on the Certificate Effective Date. If you are not actively at work on that date, coverage will become effective on the date you return to an active work status.
CERTIFICATION: I have read the completed Employee Application /Statement of Insurability and the statements and answers that pertain to me and my spouse and my children. I certify that these statements and answers are true and complete to the best of my knowledge and belief, and that the statements and answers will be used by the insurance company to determine insurability. I realize any false statement or misrepresentation in the Employee Application /Statement of Insurability may result in loss of coverage under the Certificate. I understand that no insurance will be in effect until my Employee Application /Statement of Insurability is approved and the necessary premium is paid.
I understand and agree that the coverage that I am applying for may have a pre-existing condition exclusion.
I authorize the Group Policyholder to deduct the appropriate dollar amount from my earnings each pay period to pay Continental American Insurance Company the required premium for my insurance.
I certify that I am actively at work. I certify that my spouse is not currently disabled or unable to work. I certify that I have accurately disclosed my and my spouse's usage of tobacco products in the last 12 months.
I certify, by signing below, that I am covered by a major medical policy or other coverage that satisfies the minimum essential coverage under the Affordable Care Act.
A person is guilty of insurance fraud if he intends to defraud an insurer or if he knowingly facilitates a fraud against an insurer. Fraudulent activities include submitting an Application or filing a claim that contains any false or deceptive statement.
The policy provides limited benefits. Review your policy carefully.
Date Signature of Applicant
Date Signature of Agent
Agent's Printed Name
Agent No State of Enrollment

This form is not complete unless signed and dated as indicated.

Affac.
<b>CONTINENTAL AMERICAN</b>
INSURANCE COMPANY

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Are v	ou activel	y at work?								YES N		<u> </u>		
		tobacco pro	oducts in	the last 1	2 m	onths?				YES   N		☐ YES	□ NO	
Are y						ur normal du							□ NO	
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1	Have you	ı ever been	treated fo	r or diag	nose	ed by a mem	ber of							
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2						or injury othe		□ YES	□ №	□ YES □	ON	□ YES	S 🗆 NO	
						e or fractured limb?				\				

This application is not complete unless signed and dated on the back

	Section II - Complete for Simplified Issue	Applicant	Spouse	Children				
3	In the last 7 years have you been treated for or diagnosed with cancer or any malignancy, which includes carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor? Cancer does not include basal cell or squamous cell carcinoma.	□ YES □ NO	□ YES □ NO	□ YES □ NO				
4	Have you ever been treated for or diagnosed with a) a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease), diabetes, or any liver disorder; b) kidney (renal) failure or end stage kidney (renal) disease; c) organ transplant; d) emphysema or e) now taking 3 or more medications for high blood pressure?	□ YES □ NO	□ YES □ NO	□ YES □ NO				
5	Have you ever sought advice or treatment for alcohol abuse, been arrested for driving under the influence of or while impaired by alcohol, or been arrested for or used illegal drugs or narcotics?	□ YES □ NO	□ YES □ NO	□ YES □ NO				
If you	answered <u>Yes</u> to any question for Child Coverage, indicate name of	Child/Children						
To the best of my knowledge and belief, the answers to the questions on this application are true and complete. They are offered to Continental American Insurance Company as the basis for any insurance issued.								
•	Does this coverage replace or change any existing insurance?   YES  If "Yes," provide carrier and policy number:							
may r	TFICATION: I have read the completed application and I realize any false esult in loss of coverage under the certificate. I understand that no insurate necessary premium is paid.							
Cove	age will not become effective unless you are actively at work on the date	of the enrollment a	nd the effective da	te of coverage.				
	orize my employer to deduct the appropriate dollar amount from my earning ance Company the premium required thereafter each pay period for my instance.		and pay Continenta	al American				
Dedu	ction start date							
Any appli	person who, with intent to defraud or knowing that he is facilit cation or files a claim containing a false or deceptive stateme	tating a fraud ag nt is guilty of ins	ainst an insure surance fraud.	r, submits an				
Date_	Signature of Applicant	Si	tate of Enrollment					
Date_	Signature of Agent	A	gent #					



### **CONTINENTAL AMERICAN INSURANCE COMPANY**

Columbia, South Carolina 800.433.3036

**Group Life Insurance** 

A. Information About the Employee

Name of Employee Address Date of birth (First, middle initial, last)

Address Date of birth (mm/dd/yyyy)

Employer Policyholder Name

B. Employee Beneficiary Information									
First name, middle initial, and last name of each beneficiary	Relationship	Address	Date of Birth (mm/dd/yyyy)	Social Security #	Email Address	Telephone	Percent %		
□ Primary									
□ Primary □ Contingent									
□ Primary □ Contingent									

C. Information About the Spouse

Name of Spouse
(First, middle, last)

Date of birth
(mm/dd/yyyy)

D. Spouse Beneficiary Info	ormation						
First name, middle initial, and last name of each beneficiary	Relationship	Address	Date of Birth	Social Security #	Email Address	Telephone	Percent %
□ Primary							
□ Primary □ Contingent							
□ Primary □ Contingent							
	•		•			•	Total: 100%

E. Please sign and date

Employee Signature

Date

Return to: Mail: Aflac · P.O. Box 84075 · Columbus, GA 31993 · Fax: 866.849.2974 · Email: cscmail@aflac.com

**Questions? Toll-Free:** 1.800.433.3036

Continental American Insurance Company (CAIC), a proud member of the Aflac family of insurers, is a wholly-owned subsidiary of Aflac Incorporated and underwrites group coverage.

BDF4L0717 07.06.2017

Total: 100%







Corporate Offices: One Pre-Paid Way • Ada, OK 74820 www.LegalShield.com • 800-654-7757

LegalShield is the trade name of Pre-Paid Legal Services, Inc. and its sub idiaries.

### **Select Applicable Sub idiary:**

Pre-Paid Legal Services, Inc. Pre-Paid Legal Casualty, Inc

Legal Service Plans of Virginia, Inc.
Pre-Paid Legal Services, Inc. of Florida
Pre-Paid Legal Access, Inc.

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