



**ENROLLMENT FORM FOR GROUP CATASTROPHIC MAJOR MEDICAL INSURANCE**

for residents of **Florida, Iowa, Kansas, North Carolina and South Carolina**

Underwritten by The United States Life Insurance Company in the City of New York.

A member company of American International Group, Inc.

Please print or type all information requested.

**NOTE: Proposed insureds must have a basic health insurance plan with the minimum requirements described in the brochure or Medicare Parts A & B. If not, you do not qualify for this coverage.**

Choice of Deductible:     \$35,000         \$50,000  
 Plan Selection:          Member         Member & Spouse     Member, Spouse & Children

Member's Full Name										Gender <input type="checkbox"/> Male <input type="checkbox"/> Female			
Address						City				State		Zip	
Social Security No.						Date of Birth							
Home Phone #						Work Phone #							

Complete the following for spouse and/or children, if enrolling for insurance. Use a separate sheet of paper if more space is needed.

	Name	Age	Date of Birth (mm/dd/yy)	Social Security Number	Gender (M/F)
Spouse					
Child					
Child					
Child					
Child					

<input type="checkbox"/> Please send me a bill	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semiannual	<input type="checkbox"/> Annual	
<input type="checkbox"/> Please withdraw premiums from my checking or savings account. <i>(Be sure to complete and return the enclosed Automatic Payment Option Form.)</i>	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semiannual	<input type="checkbox"/> Annual

A \$.50 per month administrative fee will be added to your bill.

I understand that this plan will not pay benefits during the first two years after the effective date for any injury or sickness any proposed insured has now, or has had in the past 12 months. I understand that this Plan requires proposed insureds to be covered under a basic medical plan. I understand that this plan will not pay any benefits for the first 70 days of hospital confinement if coverage under a health insurance plan, with the minimum requirements as stated in the brochure, is not in effect for the proposed insureds at the time of such confinement.

**Important Notice:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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 may be a crime. (Fraud provisions vary by state.)

Signature of Member: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature of Spouse (if applying): \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

To enroll, please complete this enrollment form, sign, date and return it with your first modal premium check made payable to Selman & Company:  
 ACerS Members' Insurance Program • 6110 Parkland Boulevard • Cleveland, Ohio 44124  
 Phone: 800-556-7614



Automatic Payment Option (APO)  
**Savings or Checking Account Deduction Authorization Form**

**1. Applicant's Information** *(proposed insured)*

Applicant's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Please list the Insurance Policy you wish to have premium deductions made from the account indicated below:**

Policy Number: \_\_\_\_\_ Type of Insurance: \_\_\_\_\_

**2. Financial Institution Information**

Depositor Name (Payor) \_\_\_\_\_

*(As it appears on Financial Institution Records)*

Financial Institution Name \_\_\_\_\_ Account Number \_\_\_\_\_

*(Include Branch Name)*

Financial Institution City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**3. Account Selection:** I authorize an automatic deduction from my *(please choose one)*:

**Checking Account.** Attach a sample VOIDED check.

**Savings Account.** Account Number: \_\_\_\_\_ Routing Number: \_\_\_\_\_

Premium deduction should be made:

**Monthly**     **Quarterly**     **Semi-Annually**     **Annually**

*Please include your first modal premium check made payable to Selman & Company. All subsequent premium payments will be made as indicated above.*

**4. Signature/Authorization**

*In accordance with the agreements and conditions listed below, I hereby request and authorize Selman & Company to initiate debit entries on the Financial Institution account listed herein for the purpose of paying premium. This authorization is to remain in full force and effect until Company and Depository have received written notification from me of its termination in such time and manner as to afford Company and Depository a reasonable opportunity to act on such notification. Written notification must be mailed to: Selman & Company, 6110 Parkland Boulevard, Cleveland, OH 44124-4187.*

Signature of **Depositor** \_\_\_\_\_

Print Name of **Depositor** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of **Applicant/Insured** *(If different from Depositor)* \_\_\_\_\_

Print Name of **Insured/Applicant** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**5. Agreements & Conditions**

*Automatic Payment Option (Account Deduction Authorization) is subject to the following conditions:*

1. Premium payments will be debited from your account on or about the premium due date.
2. Additional premium that may be required in order to keep policy(ies)/certificate(s) current may be drawn from your account through the use of multiple debits.
3. Selman & Company (Company) may revoke the privilege of paying premium under this Automatic Payment Option (APO) if any payment is dishonored.
4. A service fee of \$15.00 may be assessed for each dishonored payment.
5. Payment of premium under APO may be discontinued by the Company or the undersigned upon thirty (30) days written notice.
6. If APO is discontinued, an alternate payment mode acceptable to the Company will be used to remit the premiums needed to keep the policy(ies)/certificate(s) in force and current.
7. The Company will not send premium notices while APO is in effect.
8. A request for change or adjustment to the APO must be sent directly to the Company's Customer Service Department.
9. If you cancel this service, any refund of premium due you will take sixty (60) days to process.

<b>OFFICE USE ONLY</b> Insured ID: _____    APO Effective Date: _____
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