



ENROLLMENT FORM FOR GROUP CATASTROPHIC MAJOR MEDICAL INSURANCE
for residents of **New York**

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. If you have previously applied for insurance, a copy of that application must be attached.

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

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 applying 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					

- Are you, and all those for whom coverage is requested, covered under the basic major medical plan, HMO, or PPO?
 Yes No
- Or, are you, and all those for whom coverage is requested, covered by Medicare Parts A and B?
 Yes No

If YES: Name your insurer, HMO provider, PPO provider, Medicare Parts A and B, and check whether coverage is
 Group or Individual.

If NO for both questions: You do not qualify for this coverage.

<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. (Be sure to complete and return the enclosed Automatic Payment Option Form.)	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semiannual	<input type="checkbox"/> Annual

Important: Enrollment form continues on the other side.

I understand that this plan will not pay benefits during the first twelve months after the effective date for an injury or sickness I or any proposed insured(s) now have or have had in the past six months. However, if I am a resident of New York, and if I or any proposed insured was covered under another medical insurance plan that terminated within 60 days of the effective date of coverage under this plan, this limitation will be reduced by the amount of time covered under that previous plan.

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 is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Member: _____ Date: ____ / ____ / ____

Signature of Spouse (if applying): _____ Date: ____ / ____ / ____

Agent's Signature: _____ Agent's No. _____ 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

Group Policy No: E-233,619

AG5144

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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.

OFFICE USE ONLY Insured ID: _____ APO Effective Date: _____
