



**HOSPITAL INCOME
INSURANCE PROTECTION
POLICY NO. AGP-5308**

Underwritten by:
Hartford Life Insurance Company
Simsbury, CT 06089



Member Information

Your name <i>(last, first, middle)</i>		
Date of Birth / /	<input type="checkbox"/> Female	<input type="checkbox"/> Male
Address		
City	State	Zip
Home Phone () -	Work Phone () -	
E-mail Address		

Coverage Selection

I request coverage for: <input type="checkbox"/> Member Only <input type="checkbox"/> Member/Spouse <input type="checkbox"/> Member/Child(ren) <input type="checkbox"/> Member/Spouse/Child(ren)		
DAILY HOSPITAL INCOME PROTECTION BENEFIT DESIRED:		
Member	\$ _____ \$20 to \$200 in \$20 increments	<input type="checkbox"/> 3-Day Elimination
Spouse	\$ _____ \$20 to \$100 in \$20 increments	<input type="checkbox"/> 0-Day Elimination
Child(ren)	\$ _____ \$20 to \$100 in \$20 increments	

Dependent Information

Spouse Name <i>(last, first, middle)</i>	Date of Birth / /
Child Name <i>(last, first, middle)</i>	Date of Birth / /
Child Name <i>(last, first, middle)</i>	Date of Birth / /
Child Name <i>(last, first, middle)</i>	Date of Birth / /

Payment Information

<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 \$0.50 per month administrative fee will be added to your bill.

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. For CA, NJ and UT residents only: I confirm that I am covered under a health benefits plan, contract or policy.
Signature and date are required to process your application.

Signature of Member Date

Signature of Spouse *(only if applying)* Date

Please complete, sign and date this enrollment form and mail it along with your first modal premium to the address below.
Please make your check payable to Selman & Company.

**ASM Members' Insurance Program • 6110 Parkland Boulevard • Cleveland, OH 44124
1-800-556-7614**

The Hartford® is the Hartford Financial Services Group, Inc. and its subsidiaries, including issuing company of Hartford Life Insurance Company.

Policy Form #SRP-1151 A (HL) (5308)

0608 HIP ASM APP

0608ST

Important information for persons on Medicare on the back of this form.

**IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses. Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- other approved items and services

Before You Buy This Insurance

- √ Check the coverage in all health insurance policies you already have.
- √ For more information about Medicare and Medicare supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- √ For help in understanding your insurance, contact your state insurance department or state senior insurance counseling program.



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: _____
