

GROUP HOSPITAL INCOME INSURANCE ENROLLMENT FORM

Group Master Policy Holder: **PICPA Insurance Trust**

Group Master Policy Number: **1013**

Member of Pennsylvania Institute of CPAs Date of Membership: _____

Employee of Member of Pennsylvania Institute of CPAs

If an Employee: Name and Address of Member/Firm: _____

| | | | | |
|--------------------------------|--------|-----------|-------------------------|--|
| Member's/Employee's Full Name: | | | Date of Birth: | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Mailing Address: | | | Social Security Number: | |
| City: | State: | Zip Code: | Daytime Phone Number: | |
| | | | Home Phone Number: | |
| | | | Email Address: | |

You must be a member or an employee of a member of an enrolling group to enroll for coverage. The member or employee must be insured to cover dependents.

Please make your enrollment election below, enter the Daily Benefit Amount and, if you are requesting coverage for your dependents, provide their full name and date of birth. If you need more space, list additional children on a separate sheet of paper and send it to us with your enrollment form.

With respect to residents of Minnesota, are you currently insured for medical, hospital and surgical expenses under a Qualified Plan?

Yes No

If you answered No, you cannot enroll for this coverage. A Qualified Plan pays a minimum of 80% of covered expenses after payment of a deductible of \$1,000 or less, with an out-of-pocket limit no higher than \$3,000 and a lifetime limit no less than \$1,000,000 per person.

| | Daily Benefit | Full Name: | Date of Birth: |
|---|---------------|-------------|----------------|
| <input type="checkbox"/> Member/Employee | | SELF | |
| <input type="checkbox"/> Spouse | | | |
| <input type="checkbox"/> Children * | | | |
| *List all eligible children: | | | |
| | | | |
| | | | |
| | | | |

I understand and agree that coverage will not take effect until the first day of the month after my enrollment form and first premium for the required amount are received by the Plan Administrator.

With respect to residents of Virginia, I understand that during the first 12 months of my insurance or of my dependent's insurance, losses incurred for pre-existing conditions are not covered; unless, no treatment has been received for that condition, including consultation with a Physician, for at least 12 months. Pre-Existing Condition means any Injury or Sickness, for which I or my dependent(s) were diagnosed by, or received Treatment from, a Physician or other licensed practitioner of the healing arts; or took any drugs or medications; or had symptoms for which an ordinarily prudent person would have sought Treatment; within the 12 month period prior to the coverage effective date. A diagnosis or condition which results from the same or related Injury or Sickness; or from any aggravations of the Injury or Sickness are considered to be the same Injury or Sickness for the purpose of defining a Pre-Existing Condition.

With respect to all others, I understand that during the first 12 months of my insurance or of my dependent's insurance, losses incurred for pre-existing conditions are not covered; unless, no treatment has been received for that condition, including consultation with a Physician, for at least 12 months. Pre-Existing Condition means any Injury or Sickness, for which I or my dependent(s) were diagnosed by, or received Treatment from, a Physician or other licensed practitioner of the healing arts; or took any drugs or medications; or had symptoms for which an ordinarily prudent person would have sought Treatment; within the 12 month period (6 months for residents of Idaho) prior to the coverage effective date. All manifestations, symptoms, or findings which result from the same or related Injury or Sickness; or from any aggravations of the Injury or Sickness are considered to be the same Injury or Sickness for the purpose of defining a Pre-Existing Condition.

I understand that the hospital income coverage is supplemental health insurance and not a substitute for hospital or medical expense insurance, health care service plans, or major medical expense insurance.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Member's/Employee's Signature _____

Date _____



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Underwritten on Policy Form AHI-5001-A (UIC) by: Unimerica Insurance Company, Milwaukee, Wisconsin 53226
Association Administrative Address: P.O. Box 17828, Portland, Maine 04112-8828