

GROUP HOSPITAL INCOME INSURANCE ENROLLMENT FORM

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

Group Master Policy Number: **1013**

Office use only

Facets #:

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: _____

Applicant'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:	

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.

	Daily Benefit	Full Name:	Date of Birth:
<input type="checkbox"/> Applicant		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. 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. 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. 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.

Applicant'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