SET SEG
School Insurance Specialists

SUBSCRIBER APPLICATION

SUBSCRIBER

ENROLLMENT TYPE: ❍ NEW HIRE ❍ REHIRE
❍ OPEN ENROLLMENT ❍ COBRA

REASON:
❍ MARRIAGE ❍ LEGAL GUARDIAN
❍ TRANSFER ❍ LOSS OF COVERAGE

DISTRICT NAME

ACCOUNT #

EFFECTIVE DATE

Please print

SOCIAL SECURITY NO. | NAME (LAST, FIRST, MIDDLE INITIAL)

BIRTH DATE OF EMPLOYEE (MM/DD/YY) | MARITAL STATUS | GENDER

ADDRESS | CITY | STATE | ZIP CODE

JOB TITLE/OCCUPATION | EMPLOYMENT DATE (REQUIRED)

HOURS WORKED/WEEK | ANNUAL SALARY

DEPENDENTS

NAME: (FIRST, LAST IF DIFFERENT)	GENDER	SOCIAL SECURITY NO. (MANDATORY FOR ALL)	BIRTHDATE MM/DD/YY	OTHER INSURANCE?	CHECK IF APPLICABLE
SPOUSE				❍ YES ❍ NO	❍ AGE 19-26 ❍ DISABLED
CHILD				❍ YES ❍ NO	❍ AGE 19-26 ❍ DISABLED
CHILD				❍ YES ❍ NO	❍ AGE 19-26 ❍ DISABLED
CHILD				❍ YES ❍ NO	❍ AGE 19-26 ❍ DISABLED

GROUP PLANS

MEDICAL INSURANCE PLAN:
❍ ONE-PERSON ❍ TWO-PERSON ❍ FAMILY

MEDICAL PLAN NAME/CODE

HRA-WRAP: ❍ YES ❍ NO

WAIVED MEDICAL: ❍ YES ❍ NO

GROUP **DENTAL**: ❍ YES ❍ NO *If yes,* ❍ EMPLOYEE ❍ EMPLOYEE & DEPENDENT(S)

GROUP **VISION**: ❍ YES ❍ NO *If yes,* ❍ EMPLOYEE ❍ EMPLOYEE & DEPENDENT(S)

GROUP **LONG-TERM DISABILITY**: ❍ YES ❍ NO

GROUP **SHORT-TERM DISABILITY** *(If available)*: ❍ YES ❍ NO

GROUP **LIFE INSURANCE**: ❍ YES ❍ NO $ _____ *(Amount)*

GROUP **DEPENDENT LIFE** *(If available)*: ❍ YES ❍ NO

NOTE: If choosing a Disability or Life product, please make sure to complete the "ANNUAL SALARY" line above to ensure timely processing. Your application may be delayed if incomplete.

OPTIONS

BASIC LIFE AND AD&D $5,000 *(Must be selected to choose other optional coverage)*: ❍ YES ❍ NO

HOSPITAL CONFINEMENT INDEMNITY INSURANCE *(Check coverage desired)*:
❍ SELF ONLY ❍ SELF & SPOUSE ❍ SELF & CHILDREN ❍ FAMILY $_____A DAY

SHORT-TERM DISABILITY INCOME INSURANCE: WEEKLY BENEFIT DESIRED $_____ BENEFITS COMMENCE ON: ❍ 8th DAY ❍ 29th DAY

LONG-TERM DISABILITY INCOME INSURANCE: MONTHLY BENEFIT $_____

SHORT-TERM DISABILITY/LTD COORDINATED PLAN: BENEFIT DURATION_____ WEEKLY BENEFIT_____

DEPENDENT TERM LIFE INSURANCE: ❍ YES ❍ NO

SURVIVOR INCOME INSURANCE *(Includes surviving spouse and dependent children. Excludes sponsored dependents)*: ❍ YES ❍ NO

OTHER INSURANCE

Are you or any family member covered under another group insurance program(s)? ❍ YES *Please complete below* ❍ NO

Are you or any one named on this application covered by Medicare? ❍ YES ❍ NO

If you have a named child, above, whose birth parents are divorced or separated, is there a court order stating which parent is responsible for providing health insurance *(Please attach a copy of the court order)*? ❍ YES ❍ NO With whom does the child reside? ❍ FATHER ❍ MOTHER

NAME OF SUBSCRIBER | SOCIAL SECURITY NO. | DATE OF BIRTH | EMPLOYER

MEDICAL INSURANCE COMPANY NAME | EFFECTIVE DATE

DENTAL INSURANCE COMPANY NAME | EFFECTIVE DATE

VISION INSURANCE COMPANY NAME | EFFECTIVE DATE

BENEFICIARY

PRIMARY BENEFICIARY | RELATIONSHIP

SECONDARY BENEFICIARY | RELATIONSHIP

❍ I have read and understand the conditions on the reverse side of this form.

APPLICANT SIGNATURE | DATE

Signed form must be received within 30 days of requested effective date.

FORM NO. 021 REV. 4/19/19

Upload to www.setseg.org by logging in and choosing "Upload Employee Enrollment Forms" from the Employee Benefit Services menu, or email enrollment@setseg.org

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SUBSCRIBER APPLICATION

Please read the following information before completing the reverse side of this application.

THE INFORMATION ON THIS FORM AND THE FOLLOWING CONDITIONS ARE PART OF MY CONTRACT WITH SET INC. AND/OR ITS DESIGNATED UNDERWRITING INSURANCE COMPANY(IES).

I am applying for coverage under my group or association contract with SET Inc. Coverage begins on the date determined by SET Inc. and/or its underwriters. When SET Inc. accepts my application I and covered members of my family are bound by the terms of the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my dependents' eligibility for coverage when requested by SET Inc. or the appropriate insurance company(ies) underwriting my coverage(s).

Authorization: I appoint my group or association to handle all matters of coverage. They may forward any agreed deductions for coverage from my wages. I am responsible for giving notice to my group or association of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, births, or death of someone covered under the policy. I authorize the appropriate insurance company(ies) underwriting my coverage(s) and/or my physician(s) to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage, and for other purposes necessary to fulfill the underwriter's (s') contractual and statutory obligations.

Release of information: SET Inc. does not require your Social Security number, however, your group or association, Medicare, Medicaid and others do require it. SET Inc. will release information about you only when:

- You authorize it in writing.
- When it must be released to process a claim (e.g. to another insurance company). Upon your written request, SET Inc. will tell you when the information was sent.

Underwriting Insurance Companies:

- Health Insurance
- Supplemental Medical Insurance
- Basic Life, Accidental Death and Dismemberment Insurance
- Group Medical Options
- Dental Insurance
- Vision Insurance
- Group Long-Term Disability Insurance

These benefits may be underwritten and/or administered by one or more of several Insurance Companies or Third-Party Administrators, depending on the type of coverage and carrier selected by your employer. Please contact SET Inc. or your employer regarding questions related to what specific coverage and/or carrier your employer has selected