

**GROUP ENROLLMENT FORM
FOR HOSPITAL GAP PLAN™**



Administered by:
Special Insurance Service (SIS)
6509 Windcrest Drive, Suite 200
Plano, TX 75024

Last Name (maiden name)		First Name	Full Middle Name	Suffix	Sex <input type="checkbox"/> M <input type="checkbox"/> F
Age	Date of Birth (mo, day, yr)	Social Security Number	Home Phone # ()	SELECT PLAN DESIRED <input type="checkbox"/> Employee Only/HMC: Z <input type="checkbox"/> Employee & Spouse/HMC: Y <input type="checkbox"/> Employee & Child(ren)/HMC: V <input type="checkbox"/> Employee & Family/HMC: X	
Number and Street			Work Phone # ()		
City		State	Zip Code		
Employer	Occupation	Date of Employment		Requested Effective Date:	
Plan Selected: _____	Premium: \$ _____		Plan Code: _____		

I hereby enroll or change, as indicated above, this group insurance coverage for which I am eligible. I authorize my employer to deduct my contributions, if any, from my pay. **ANY CHANGE REQUIRES WRITTEN NOTICE.** I understand and agree that no coverage will take effect until a Policy or Certificate is issued. I further understand and agree that this coverage will not become effective or remain in effect for any person to be covered who is not also covered by a Major Medical or Comprehensive Medical policy which includes managed care and this coverage may contain Pre-Existing Limitations.

NOTICE: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of insurance fraud.

AGENT (where required by law)

Date

Agent No.

SIGNATURE (applicant)

M-2467-SIS
WOMIB

Please indicate if Dependent is a new dependent or an add-on:

New _____ Add-on _____

PLEASE PROVIDE NAMES OF DEPENDENTS TO BE COVERED:

<u>Name</u>	<u>Relationship</u>	<u>Date of Birth</u>	<u>Effective Date of Coverage</u>	<u>Social Security #</u>
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