Georgia Society of CPAs Enrollment Form

Swett&Crawford A CGSC Company
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COMBINED INSURANCE

Send completed, signed form via secure fax to (877) 291-3287

EMPLOYEE'S NAME (First, Last)	Gender	Date of Birth (Mo/Day/Year)	Date of Hire (Mo/Day/Year)
EMPLOYEE'S HOME ADDRESS (Street, City, State, ZIP)		HOME PHONE #	SOCIAL SECURITY #
EMPLOYEE #	DEPARTMENT	WORK PHONE #	EMPLOYER NAME
GROSS ANNUAL INCOME	EMPLOYEE'S OCCUPATION	DESCRIPTION OF JOB DUTIES	
BENEFICIARY'S NAME (First, Last)		RELATIONSHIP TO EMPLOYEE	

***The Employee will be the Beneficiary of any coverage issued on a Spouse or Child.**

	YES	NO
Have you used tobacco in any form in the last 12 months?		
If applying for coverage, has your spouse used tobacco in any form in the last 12 months?		
Will any of the coverage applied for replace any existing coverage of the same type?		
Do you have a comprehensive health care coverage in force? **If no, Critical Illness coverage will not be issued**.		
I am actively at work, performing in the usual manner of all of my regular duties at my usual place of employment. (**If 'NO' the employee cannot apply for any coverage listed below).**		

Coverage Type	Benefit Amount or Plan Type	Elimination Period	Benefit Period	Who will be covered? Benefit Amount (If Applicable) Me	Spouse	Children	Modal Premium
Accident Champion		N/A	N/A				
Critical Illness Champion		N/A	N/A				
Disability Income Protector					N/A	N/A	
Cancer Protector		N/A	N/A				
LifeTime Benefit Term (Employee)		N/A	N/A		N/A	N/A	
LifeTIme Benefit Term (Spouse)**		N/A	N/A	N/A		N/A	
LifeTime Benefit Term (Children)**		N/A	N/A	N/A	N/A		
LBT Child Term Rider? **(Can apply for either LBT for child or for Child Term Rider…but not both.)**		N/A	N/A	N/A	N/A		
LBT Accidental Death Rider?		N/A	N/A			N/A	

Employee MUST apply for LBT coverage in order to apply for Spouse of Children LBT coverage.

Subtotal	
Monthly Administrative Fee	$1.00
Total Modal Premium	

List all eligible persons to be covered by any of the above plans

Name	Date of Birth (Mo/Day/Year)	Relationship	Gender	
		Spouse		
		Child		
		Child		
		Child		

I elect to participate in benefit plan(s) as indicated above and acknowledge that I am responsible for payment of the above premiums. I also understand that there is a $1.00 per month fee that is not part of the insurance premiums that is used to pay for administrative and billing expenses.

I further understand that the Critical Illness coverage is not meant to be a substitute or replacement for major medical insurance.

X City: State: Date:

Signature of Employee

Please answer the following questions when applying for LifeTime Benefit Term.

	Employee		Spouse	
	Yes	No	Yes	No
Does the Applicant or Spouse have any other long term care insurance in force? (If yes, provide details below)				
Did the Applicant or Spouse have any long term care insurance policy lapse during the last 12 months?				
Are you covered by Medicaid?				
Do you intend to replace any of your medical or health insurance coverage with this Certificate?				
Are you considering surrendering, forfeiting or otherwise terminating your existing life insurance contract?				

Details: _____

_____

If you wish to designate a secondary addressee to receive notification of a possible lapse in coverage please indicate below:

Secondary Address (Full legal name) _____

Mailing Address (Street, City, State, ZIP)

_____

_____

X City: State: Date:

Signature of Employee

AGENT CERTIFICATION: I certify that I met with the employee named in this enrollment form at their place of work stated in this enrollment form and that the employee is actively at work, performing in the usual manner of their regular duties at their usual place of employment.

X AGENT CODE: Date:

Agent Signature