Colonial Life & Accident Insurance Company
P.O. Box 1365, Columbia, SC 29202-1365

GROUP HOSPITAL CONFINEMENT INDEMNITY INSURANCE ENROLLMENT FORM

Named Insured Section

Named Insured (First, MI, Last)	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Social Security No.

Home Address – Street	City	State	Zip Code	Employee ID/Payroll No.

Email Address	Home Phone No. Business Phone No.

Date Employed	Occupation/Job Title	Annual Income	Hrs. Worked/ Week	Employee Class

Billing Section

Employer Name	Employer Address (Street-City-State-Zip)	Section/Dept. No.
Johnson Employer Support Services	**727 N West Ave El Dorado AR 71730**	

Spouse Section

Is your spouse applying for coverage? If yes, provide identifying information below. Yes ☐ No ☐

Name of Spouse (First, MI, Last)	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.

Plan Section

Type of Coverage	Base Plan Code(s)	P = Pre-Tax A = After-Tax	Monthly Premium
☐ Named Insured ☐ Named Insured & Spouse ☐ Named Insured & Dependents ☐ Named Insured, Spouse & Dependents	GM2N T1NN HSBN	P☐ A☐	

Agreement Section

I understand that the coverage applied for will not pay benefits for any loss incurred during the first 12 months after the issue date for a disease or physical condition that I now have or have had in the past. By applying for the coverage indicated above, I am requesting cancellation of existing Hospital Confinement Insurance with Colonial Life & Accident Insurance Company (base plan and all applicable riders) if the coverage applied for is issued. If, for any reason the coverage applied for is not issued, this request for cancellation shall be null and void. With my signature below, I confirm I have read and understand the Fraud Statement printed on the following page. I hereby state the statements are true and have been completed to the best of my knowledge and belief.

Signed at: City_____ State _____ Date _____
mm/dd/yyyy

(x)_____
Signature of Proposed Insured (if applicable)

Agent Section

I hereby certify that: (a) all information set forth above is correct to the best of my knowledge and belief; (b) I have complied fully with the underwriting rules; (c) I have explained the proposed insurance coverage in detail.

Date _____ (x)_____
Signature of Licensed Agent (if applicable)

Agent Name Amanda Ahne License No. 275919 Code No. 689939