# Hospital Indemnity Insurance Plan
# Enrollment form

*Exclusively for New York MBA members aged 64 and younger*

**Group policyholder:** Military Benefit Association
**Policy number:** AGP-40004
**Promo Code:** PODHP3

***To activate this exclusive coverage, complete this form and mail to:***

**Military Benefit Association**
14605 Avion Parkway
PO Box 221110
Chantilly, VA 20153-1110

## Step 1 | Enter member information

Please verify your information below and complete where needed.

| | |
|---|---|
| **Member name** | **Home address** |
| **Member's date of birth** ____ / ____ / ____<br>**Gender** ❑ Male ❑ Female | **Rank/Branch of Service**<br>**Duty Status** ❑ Active ❑ Retired ❑ AGR ❑ Separated ❑ Federal Employee |
| **Member's Social Security number** | |
| **Phone** ( ) | **Email** (Internal use only — for important updates and member bulletins.) |

### Spouse/partner information (complete only if enrolling)

| | |
|---|---|
| **Spouse's/partner's full name** | |
| **Spouse's/partner's date of birth** | **Gender**<br>❑ Male ❑ Female |

### Dependent information *(complete only if enrolling — if more than 4 child(ren), attach additional sheet)*

| | | | |
|---|---|---|---|
| **Child(ren) name:** | **Date of birth:** | **Child(ren) name:** | **Date of birth:** |
| **Child(ren) name:** | **Date of birth:** | **Child(ren) name:** | **Date of birth:** |

## Step 2 | Enroll and Confirm your coverage

❑ **YES,** enroll me in the MBA Hospital Indemnity Plan. I understand I have 30 days to review my Certificate of Insurance at no risk.

Daily Hospital Confinement $240 per day for 90 days

## Step 3 | Choose your payment method

**Choose one:** ❑ Quarterly Payment (Monthly Premium x 3) ❑ Semi-Annual Payment (Monthly Premium x 6) ❑ Annual Payment (Monthly Premium x 12)

**Select Payment Method:** ❑ **EFT (Monthly deduction only)** ❑ **Credit Card** ❑ **Check**

(Please make check payable to Military Benefit Association.)

### Complete for EFT authorization:

_____

Name and address of Bank, Savings & Loan, Credit Union, etc., where you have a personal checking account. (Attach a voided check.)

_____

Routing/Transit Number (First 9 digits from the lower left corner of your personal check). If your checking account is through a Credit Union, please contact them for the number.

_____

Checking Account No.

_____

Member's Name (Please Print)

❑ Yes please deduct my EFT Payments for MBA Hospital Indemnity Plan

_____

Signature (as it appears on depository records) Date

**IMPORTANT: Remember to attach a voided check to this authorization.**

### Complete for credit card authorization:

_____

Member/Applicant Name as it appears on card (please print)

_____

Billing Address

_____

City State Zip

**I authorize Military Benefit Association to charge my:**

SELECT TYPE OF CARD: ❑ VISA ❑ Master Card ❑ Discover

_____ _____

Card Number Expiration Date

Please charge my card automatically for recurring payments. ❑ Yes ❑ No

(You will not be billed for future payments, they will be deducted automatically)

I hereby authorize Military Benefit Association to initiate charges to the credit card indicated above. These changes will be for the amount(s) of my premium payments based on the frequency selected above at the regular rates applicable to these premiums. It is understood that the amounts of these debits will be adjusted by MBA in accordance with any applicable premium increases or decreases.

My premium is due and payable on the first of each month depending on the frequency of payment that I select above. I agree that if any such debit is dishonored, whether with or without cause and whether intentionally or unintentionally, MBA and the depository institution shall be under no liability whatsoever even if termination of insurance results. This agreement is to remain in full force and effect until MBA has terminated it upon 60 days notice to me, or received notification from me of its termination in such time and manner as to afford MBA a reasonable opportunity to act on it.

## Step 4 | Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide all of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your administrator or your own legal advisor.

A primary beneficiary is the beneficiary or beneficiaries that you name to receive the benefits if they are living at the time of your death. The primary beneficiaries are the first in line to receive death benefits. Contingent beneficiaries, or secondary beneficiaries, are those named to receive the insurance proceeds if no primary beneficiary is alive at the time you die.

| Primary Beneficiary | | | | |
|---|---|---|---|---|
| **Primary Beneficiary Name:** | **Social Security:** | **Date of Birth:** | **Relationship:** | **Percentage:** |
| **Address: (Street, City, State, Zip)** | | **Phone Number:** | | |

The beneficiary for insurance on the lives of your dependents will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions. A beneficiary for member's Hospital Indemnity Insurance may be changed upon written request.

Spousal Consent: Consent For Community Property States Only: If you live in a community property state – Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington and Wisconsin – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Disclaimer: Spousal consent does not apply to ERISA plans. Certain tribal jurisdictions may also require spousal consent. Please see your Administrator for details.

This will represent that, as spouse of the Member named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group Hospital Indemnity Insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent under this plan.

Signature of Member's spouse: _____ Date: _____

## Step 5 | Please read, sign and date

**Confirmation**

I hereby confirm my enrollment in the MBA Hospital Indemnity Insurance Plan. Please process my enrollment form and send my Certificate of Insurance immediately. I understand I must be an MBA member to be eligible for coverage. I hereby certify that the above statements are complete and true to the best of my knowledge. I understand that this Hospital Indemnity Plan will not cover pre-existing conditions (conditions for which I received medical advice or treatment within 12 months) until the coverage has been in effect for 12 months. I understand the above coverage will become effective on the first day of the month following receipt of my enrollment form and first premium payment. I further understand that new conditions will be covered immediately.

**I hereby attest that I have major medical health insurance or Medicare that meets the requirements of minimum essential coverage as defined by the Affordable Care Act.**

✔ _____

Member signature (as it appears on depository records) Date

✔ _____

Spouse/Partner Signature (if enrolling) Date

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Coverage will be issued upon receipt of this form and will begin the first day of the month after your premium is received.

**Hospital Indemnity Form Series includes GBD-2800, GBD-2900, or state equivalent.**

**Fraud notice(s)**

**For Residents of Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**For Residents of Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**For Residents of Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For Residents of Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**For residents of Virginia:** Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries including issuing company Hartford Life and Accident Insurance Company, Hartford, CT 06155.

# Get answers to your questions

about the MBA Hospital Indemnity Insurance Plan

*Speak to licensed specialists for more information*

**Call 1-855-887-9220**