Effective Date_____

Voluntary Benefits Enrollment Form

Arc of East Central
Iowa

Employee Name:_____SS#_____DOB____/____/_____Gender_____

Date of Hire ___/___/_____ Average Hours worked per week _____ Phone Number _____

Marital Status: Single/ Married Occupation_____

Address:_____City_____State_____Zip_____

Have you or your spouse used tobacco in the last year? Applicant YES___NO____ Spouse YES___NO____

Primary Beneficiary:_____Relationship:_____Contingent Beneficiary:_____Relationship_____

DEPENDENT INFORMATION

Spouse:_____DOB____/____/_____Gender_____

Child:_____DOB____/____/_____Gender_____

Child:_____DOB____/____/_____Gender_____

Child:_____DOB____/____/_____Gender_____

Child:_____DOB____/____/_____Gender_____

☐ YES ☐ NO Assurity Accident

Circle Coverage Level Elected (semimonthly amounts listed)- Must Answer All Questions That Apply for Coverage to be Issued

Plan 1	Employee Only- $7.28	Employee + Children- $14.98	Employee + Spouse- $12.66	Family- $22.18
Plan 2	Employee Only- $10.12	Employee + Children- $19.94	Employee + Spouse- $17.56	Family- $29.71

1. Are you employed at least 20 hours per week, working normally scheduled hours and able to perform the regular duties of your job? ☐ YES ☐ NO **If "NO" you and your dependents are not eligible for coverage**

☐ YES ☐ NO Assurity Critical Illness

Check Coverage Level Elected SEE BROCHURE FOR PREMIUM AMOUNTS Must Answer All Questions That Apply for Coverage to be Issued

$5,000 Benefit	☐ Employee/Employee + Children	☐ Employee + Spouse/Family
$10,000 Benefit	☐ Employee/Employee + Children	☐ Employee + Spouse/Family
$15,000 Benefit	☐ Employee/Employee + Children	☐ Employee + Spouse/Family
$20,000 Benefit	☐ Employee/Employee + Children	☐ Employee + Spouse/Family
$25,000 Benefit	☐ Employee/Employee + Children	☐ Employee + Spouse/Family
$30,000 Benefit	☐ Employee/Employee + Children	☐ Employee + Spouse/Family

1. Are you employed at least 20 hours per week, working normally scheduled hours and able to perform the regular duties of your job? ☐ YES ☐ NO **If "NO" you and your dependents are not eligible for coverage**

☐ **YES** ☐ **NO**

Assurity Hospital

Circle Coverage Level Elected (semimonthly amounts listed)- Must Answer All Questions That Apply for Coverage to be Issued

Plan 1	Employee Only- $11.45	Employee + Children- $22.09	Employee + Spouse- $23.24	Family- $33.88
Plan 2	Employee Only- $13.71	Employee + Children- $26.32	Employee + Spouse- $27.87	Family- $40.48

1. Are you employed at least 20 hours per week, working normally scheduled hours and able to perform the regular duties of your job? ☐ **YES** ☐ **NO** **If "NO" you and your dependents are not eligible for coverage**

I understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class; b) I must have satisfied the policyholder waiting period; c) the group must have met the Insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively at work on the effective date (according to the Insurer's rules); and f) the first month's premium must have been received by the underwriting company at its administrative office. I certify that the statements and answers provided by me, are complete and true, are correctly and fully recorded and no information was withheld or omitted.

I also authorize my employer to deduct from my salary or wages, if applicable, the necessary premium, post-tax, for the coverages requested. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability may be required should I desire to apply for it at a later date. Any such application may be declined on the basis of such proof.

Signature_____ Date_____