

Voluntary Benefits Enrollment Form

TrueNorth Companies

Employee Name: SS# DOB / / Gender

Date of Hire / / Avg Hours worked/week Phone Number

Marital Status ☐ Single / ☐ Married Date of Marriage / / Annual Salary N/A Occupation

Address: City State Zip

Primary Beneficiary: Relationship

Contingent Beneficiary: Relationship

DEPENDENT INFORMATION

Spouse: DOB / / SS# Gender

Child: DOB / / Gender US Citizen ☐ YES ☐ NO

Child: DOB / / Gender US Citizen ☐ YES ☐ NO

Child: DOB / / Gender US Citizen ☐ YES ☐ NO

Child: DOB / / Gender US Citizen ☐ YES ☐ NO

☐ YES ☐ NO

ACCIDENT PLAN- Assurity

IF YES Circle Coverage Level Elected (bi weekly cost listed)- Must Answer All Questions That Apply For Coverage to be Issued

Plan 1 ☐ Employee Only- \$6.73	Employee + Children- \$13.83	Employee + Spouse- \$11.69	Family- \$20.47
Plan 2 ☐ Employee Only- \$9.34	Employee + Children- \$18.41	Employee + Spouse- \$16.22	Family- \$27.42

1. In the past 90 days have you been working less than 30 hours per week or unable to perform any duties of your primary occupation?
- YES ☐ NO ☐

☐ YES ☐ NO

CANCER INSURANCE-Prosperity

IF YES Circle Coverage Level Elected (bi weekly cost listed)- Must Answer All Questions That Apply For Coverage to be Issued

Plan 1 ☐ Employee Only-\$10.30	Employee+Children-\$13.86	Employee+Spouse-\$18.95	Family-\$20.97
Plan 2 ☐ Employee Only-\$13.23	Employee+Children-\$17.83	Employee+Spouse-\$25.31	Family-\$28.04
Plan 3 ☐ Employee Only-\$16.79	Employee+Children-\$22.32	Employee+Spouse- \$32.57	Family-\$36.01

1. Are you actively at work on a FT basis and able to perform the regular duties of your occupation? YES ☐ NO ☐

If "NO" you and your dependents are not eligible for coverage

2. Is anyone proposed for coverage covered by any Title XIX program (i.e. Medicaid)? YES ☐ NO ☐

If YES list Name(s) _____, who will be excluded from coverage

If "YES" to question 2 then that individual will be excluded from coverage

☐ YES☐ NO**CRITICAL ILLNESS INSURANCE- Assurity****If electing coverage does employee use tobacco?**☐ YES☐ NO**If Electing Coverage Circle Coverage Level Elected. Must Answer All Questions That Apply For Coverage to be Issued.**

Please refer to the brochure for your biweekly premium amount.

\$5,000 benefit	Employee Only	Employee + Children	Employee + Spouse	Family
\$10,000 benefit	Employee Only	Employee + Children	Employee + Spouse	Family
\$15,000 benefit	Employee Only	Employee + Children	Employee + Spouse	Family
\$20,000 benefit	Employee Only	Employee + Children	Employee + Spouse	Family
\$25,000 benefit	Employee Only	Employee + Children	Employee + Spouse	Family
\$30,000 benefit	Employee Only	Employee + Children	Employee + Spouse	Family

1. Are you actively at work on a FT basis and able to perform the regular duties of your occupation? YES ☐ NO ☐

If "NO" you and your dependents are not eligible for coverage

2. Is anyone proposed for coverage covered by any Title XIX program (i.e. Medicaid)? YES ☐ NO ☐

If YES list Name(s) _____, who will be excluded from coverage

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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, and for my dependents, they must not be disabled (unless included by a special endorsement), 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 pre-tax for the coverages requested; I cannot change my election midyear without a qualifying event. I understand that if I refuse any coverage for which I am eligible, satisfactory proof of insurability will 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** ____/____/____