

To Apply: Please complete this form and return to:
ASCE Member Insurance Program Administrator, 1200 E Glen Ave, Peoria Heights, IL 61616-5348

Questions: Please call 1.800.650.2723

ASCE MEMBER INSURANCE PROGRAM

GROUP \$3,500 FIRST DIAGNOSIS CANCER INSURANCE PLAN APPLICATION

PLEASE PRINT IN INK OR TYPE. DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

PART I Personal Info

1. Member Information:

Member's Full Name _____
Last First Middle Initial

Home Street Address _____

City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____

Fax (_____) _____ E-mail _____

For internal use only. E-mail address will never be sold or shared.

Member:	If in addition to yourself, you are applying for family coverage, complete below as applicable.	Date of Birth: MO./ DAY / YR.	Sex:
		____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F
Spouse:	Name if proposed for insurance (First/MI/Last)	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F
Child*:	Name if proposed for insurance (First/MI/Last)	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F
Child*:	Name if proposed for insurance (First/MI/Last)	____/____/____	<input type="checkbox"/> M <input type="checkbox"/> F

*If more than two children are proposed for insurance, attach a separate sheet. Please **sign and date** the additional sheet.

Are you or any dependents eligible for Medicare? Yes No

2. Membership Affiliation:

Are you now a member of the ASCE? Yes No (Association Membership is required for participation in this plan.)

ASCE Membership # _____ Exp. Date: _____

3. Payment Option Selection: Choose only one.

Option 1: Direct Billing: Following your initial billing, you will be billed (Choose one):
 Quarterly Semiannually

Option 2: Electronic Funds Transfer: I request and authorize the ASCE Group Insurance Program to make monthly withdrawals against the account specified on the attached voided check, statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Cancer Expense Insurance Plan (Enclose a VOIDED check or deposit slip, as applicable).

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT _____ DATE _____

Option 3: Credit Card: I authorize premium contributions to be charged to my credit card monthly:

MasterCard Credit Card # _____ Exp. Date _____

Visa Discover

American Express

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT _____ DATE _____

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4. Insurance Requested: Refer to brochure for eligibility and coverage description.

A. Check boxes for coverage desired: **MONTHLY Premiums:**

Member Only \$12.95 (per month)

Member and Family \$19.95 (per month)

B. **To the best of your knowledge and belief**, have you or your dependents (if applying for dependent coverage) ever received treatment or have been medically advised of Cancer (excluding Skin Cancer), Leukemia or Hodgkin's Disease during the last 5 years (12 months in TX)?

Yes No

(Treatment means medical and surgical care by a licensed provider to detect or cure cancer. This includes examination, diagnostic procedures, surgery [including pre- and post-operative care], prescribed medication and the application of remedies and therapy. It does not include any diagnostic procedures or examinations performed to monitor a previous removal or remedy of Cancer, provided there is no positive diagnosis of Cancer or of a recurrence of Cancer.)

If you answered "Yes," please indicate the name(s) of the person(s) and their corresponding medical condition(s): _____

It is understood that any person listed above will not be eligible for coverage except any person listed with Skin Cancer. Any person listed with Skin Cancer will be eligible for coverage. Benefits, however, will not be payable for Skin Cancer during the first 12 months of coverage. It is understood that no benefits will be payable for expenses incurred during the first 12 months of coverage for any cancer diagnosed or treated within the first 45 days after the insured person's effective date of coverage (**NOT APPLICABLE TO RESIDENTS OF AZ, MO, TX & WI.**)

Your coverage will be effective on the first day of the month following acceptance of your application, provided your first premium is paid and you are not hospital-confined on that date.

IMPORTANT NOTICE TO PERSONS ON MEDICARE: This policy or certificate duplicates some Medicare Benefits THIS IS NOT A MEDICARE SUPPLEMENT INSURANCE POLICY

This policy or certificate provides limited benefits, if you meet the policy conditions, for hospital and medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy or certificate. It does not pay your Medicare deductibles or coinsurance and is not a substitute for a Medicare supplement insurance policy.

This policy or certificate duplicates Medicare benefits when it pays: hospital or medical expenses up to the maximum stated in the policy.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services (regardless of the reason you need them).

These include: • hospitalization-physician services • hospice • other approved items and services

Before You Buy This Policy:

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- For help in understanding your insurance, contact your state insurance department or state senior insurance counseling program.

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

FL Residents: 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.

PA Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 and subjects to criminal and civil penalties.

AR, CO, DC, KY, NM, OH, OK and TN Residents: 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 crime and may be subject to fines and confinement in prison.

Member's Signature **X** _____ Date _____

Spouse's Signature **X** _____ Date _____

(Necessary only if spouse coverage is requested)

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