ASCE | MEMBER INSURANCE

GUARANTEED ACCEPTANCE

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

THE HARTFORD
Hartford Life and Accident Insurance Company
Simsbury, CT 06089

AGP-5429

ASCE MEMBER INSURANCE PROGRAM

SHORT-TERM RECOVERY INSURANCE PLAN ENROLLMENT FORM

Please print or type all information requested.

AUTHORIZED FOR:

Member's Full Name ____
Last First Middle Initial

Billing Address ____
Street City State Zip

1. Please select who will be covered:

☐ Member ☐ Member's Spouse (**Note:** Member must sign up in order for spouse to be covered)

2. Please complete:

Date of Birth: ______/______/______ Sex: ☐ M ☐ F Date of Birth: ______/______/______ Sex: ☐ M ☐ F

Phone Numbers : Work: (______) ____________________ Home: (______) ____________________

Fax: (______) ____________________ Email:____________________
FOR INTERNAL USE ONLY. WILL NOT BE SHARED OR SOLD

3. 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:____________________

4. 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 Group Short-Term Recovery 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
☐ Visa ☐ Discover
☐ American Exrpress

Credit Card #____________________ Exp. Date__________

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

5. Please sign and date:

☐ I hereby confirm enrollment in the ASCE-endorsed Short-Term Recovery Insurance Plan. Please process my Enrollment Form and send me a Certificate of Insurance for protection under this guaranteed plan immediately.

I understand I must be an ASCE member age 65 or older and covered by Medicare to be eligible for coverage. I understand that this plan will not cover Pre-existing Conditions (conditions for which medical advice or treatment was rendered or recommended by a physician for those being enrolled within six months of this new coverage) unless six months have passed from the effective date of this new coverage or until I have gone treatment free for the condition for six consecutive months, whichever is earlier. I understand that the above coverage will become effective on the first day of the month following receipt of my Enrollment Form and first premium payment.

Member's Signature **X**____________________________________ Date __________

Spouse's Signature **X** ____________________________________ Date __________

Underwritten by:
Hartford Life and Accident Insurance Company
The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaties, including issuing company of Hartford Life and Accident Insurance Company

Policy Form #SRP-1151 (HLA) (5429)

SEND NO MONEY NOW!
You will be billed later

Be Sure To Sign This Page

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