



from the Domestic Accident & Health Division of the AIG Companies®

Please Print

for Group Accident Indemnity Insurance

Underwritten by

● NATIONAL UNION FIRE INSURANCE COMPANY OF PITTSBURGH, PA. Executive Offices: 70 Pine Street, New York, NY 10270

(Herein called the Company)

Group Policyholder: Risk Reducers, LLC

Requested Effective Date: _____

Applicant's Name: _____

Applicant's Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Daytime Phone Number: _____

Gender: Male Female Date of Birth: _____ E-mail Address: _____

Coverage: Applicant Only Applicant and Spouse Applicant and Child(ren) Family

Plan Selection (select one): SecureCare 500 Individual: \$132 Plus Spouse: \$205 Plus Child(ren): \$216 Family: \$279

SecureCare 1000 Individual: \$203 Plus Spouse: \$340 Plus Child(ren): \$368 Family: \$495

Disability Income option (select one): \$1,500/mo. (6 months) Ages 17-49: \$65 Ages 50-69: \$82

Spouse's Name: _____ Date of Birth: ___/___/___ SSNumber: _____

Beneficiary (Please print full name): _____ Relationship: _____

*The applicant will be the beneficiary for his or her spouse and/or dependent children if dependent coverage is selected unless designated otherwise.

Dependent Information

Name	Date of Birth	SS#	Gender (M/F)
Dependent: _____			
Dependent: _____			
Dependent: _____			

By signing below, I and the individuals named herein are eligible for insurance and understand that coverage will not begin until the effective date shown in the coverage document.

I authorize Homeland HealthCare to collect any and all premiums due for this coverage.

Fraud Warning: Any person who knowingly and with intent, defrauds or deceives any insurance company by submitting an application or filling a claim that contains any false or incomplete information, or conceals information for the purpose of misleading, is guilty of insurance fraud, which is a felony and subject to criminal and/or civil penalties.

Applicant's Signature _____

Date _____



Payment Information for Automatic Deduction of Monthly Premiums

Applicant Name: _____

Bank Information

Bank Name: _____

Bank Routing Number (9digits):

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Bank Account Number:

Name on Account:

Please note:

Monthly premiums are drafted on or about the 25th of each month. *Ex. March premium will be drafted on February 25.*

By signing below, I authorize Homeland HealthCare to collect any and all premiums due for this policy coverage.

X Applicant Signature: _____

Date: _____