Homeland HealthCare

AIG AIG Companies

SecureCare

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

Sold Case Form - Employees

GROUP PROFILE

Print or Type

Legal Name of Company ____________________

Requested Enrollment Period (start) ____________________ (end) ____________________

Requested Effective Date of Coverage ____________________ IRS Reporting Number ____________________

Street Address ____________________ P.O. Box (If Applicable) ____________________

City ____________________ State _____ Zip _________ County ____________________

Phone Number _____._____.__________ Nature of Business ____________________ SIC ____________

Business Type ☐ Corporation ☐ Association ☐ Partnership ☐ Sole Proprietorship ☐ Other ____________________

Other Locations or Affiliated Companies/Subsidiaries to be Included ☐ No ☐ Yes, list name(s) and location(s)

____

____

Main Contact ____________________ Title ____________________

Phone Number ____.____.________ Fax Number ____.____.________ E-Mail ____________________

ELIGIBILITY

Number of Eligible Employees ____________________ Number of Enrolled Employees ____________________

Domestic Partner Coverage ☐ Yes ☐ No

Dependents Coverage ☐ Yes ☐ No Age Limit ☐ To age 19, students to age 23 ☐ Other ____________________

Type of Funding

☐ 100% Company Paid

☐ 50 - 99% Company Paid

☐ 10 - 49% Company Paid

☐ Less than 10% Company Paid

Eligibility Waiting Period

New Employees ☐ First day of month coinciding with or following _______ days of employment.

☐ Other ____________________

Present Employees ☐ All are eligible immediately, regardless of length of service.

☐ Only those who have satisfied the waiting period are eligible. (Provide hire dates.)

Eligibility Hours Worked Per Week

☐ Full time employees working 30 or more hours ☐ Other ____________________

RATES & PLANS

☐ SecureCare 250 ☐ SecureCare 500 ☐ SecureCare 750 ☐ SecureCare 1000

Individual Only $__________ Indvidivual + Spouse $__________ Indvidivual + Children $__________ Individual + Family $__________

Rate Guarantee ☐ 24 months ☐ Other _____________ Commission _____________ %

(continued on back)

ADMINISTRATIVE

Will this insurance replace similar coverage? ☐ No ☐ Yes (Show the name of carrier and dates of coverage)

Carrier ______________________________ Effective Date ____/____/____ Termination Date ____/____/____

ENROLLMENT AND BILLING INFORMATION

☐ Paper ☐ Web ☐ Phone ☐ Laptop (face-to-face)

Billing Delivery Method ☐ Web (preferred) ☐ Paper ☐ Automated (contact us for details) ☐ Other

Billing Option

☐ ACM/ Bank Draft

Refunds

☐ Credit Next Bill ☐ Check to Plan Sponsor (post-tax plans only)

Membership Maintenance

☐ Manual ☐ Tape ☐ Electronic Transfer (For Tape or Electronic Transfer Attach Format or indicate IS Contact Person below)

Please Provide an Eligibility and Billing Service Contact Person

Eligibility Contact ______________________________ Title ______________________________

Phone Number ____.____.________ Fax Number ____.____.________ E-Mail ______________________________

Billing Contact ______________________________ Title ______________________________

Phone Number ____.____.________ Fax Number ____.____.________ E-Mail ______________________________

Deliver Administration Package to ☐ Group ☐ Broker ☐ AIG Representative

THE EMPLOYER UNDERSTANDS AND AGREES

- The requested insurance will not become effective unless National Union Fire Insurance Company of Pittsburg, Pa., or AIG Life Insurance Company receives and approves the enrollment form.
- Being actively at work is a requirement for coverage.
- No waiver or change will bind National Union Fire Insurance Company of Pittsburg, Pa., or AIG Life Insurance Company unless signed by our officer.

Signature ______________________________ Date ____/____/____

Name and Title (Print) ______________________________

AIG Representative ______________________________ Region/Branch Code ______________________________

AGENT INFORMATION

Company ______________________________ Representative ______________________________

Address ______________________________

City ______________________________ State ______ Zip Code __________ Phone Number ____.____.________

IRS Reporting Number ______________________________ Dept. of Insurance License Number ______________________________

To be completed by AIG Underwriting

Policy Number	Effective Date	U/W Approval ☐ Yes ☐ No	AIG Producer Code