COMBINED INSURANCE COMPANY OF AMERICA
Enrollment form for Group Accident Insurance

Home Office: Chicago, Illinois
FORM # C14059R

I am applying for this coverage based on the following information:

(Home Office Use)	Enrollment Date:

ACTION REQUESTED: ☒ New Certificate ☐ Reinstatement ☐ Conversion ☐ Certificate Change

EMPLOYEE'S (Proposed Insured) NAME (First MI Last)	☐ Male ☐ Female	Birthdate: Mo/Day/Yr	Age
EMPLOYEE'S HOME ADDRESS (Street, City, State, Zip)		Social Security No.	Employee ID#
Landline Phone No.	Mobile Phone No.	Email	
EMPLOYER NAME	POLICYHOLDER NAME EMPLOYEE	Hire Date: Mo/Day/Yr	Gross Annual Income
Occupation POLICE			
BENEFICIARY'S Full Name	Relationship	CONTINGENT BENEFICIARY'S Name	Relationship

Are you actively at work at least 17½ hours each week? Yes ☒ No ☐

COVERAGE FOR: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Children ☐ Employee, Spouse & Children

List all eligible persons to be covered on this plan: Employee; Spouse; and Your Children age 26 or under.

Name(s)	DOB: Mo/Day/Yr	Relationship	Sex
Employee	(as above)	Self	(as above)
		Spouse	M ☐ F ☐
		Child 1	M ☐ F ☐
		Child 2	M ☐ F ☐
		Child 3	M ☐ F ☐
		Child 4	M ☐ F ☐

Spouse includes a Eligible Domestic Partner/Civil Union Partner who resides with and is financially interdependent with the Applicant, as defined in the Certificate.

Plan: See Certificate Schedule CIRCLE: DIAMOND PLATINUM	PREMIUM - Mode ☐ Weekly (52) ☒ Monthly (12) ☐ Bi-Weekly (26) ☐ Semi-Monthly (24) ☐ _____
Total Premium Per Pay Period:	$

It is very important that you review your enrollment form carefully. Misstatements or omissions could cause an otherwise valid claim to be denied. The effective date of approved coverage will be determined as set forth in the certificate of coverage provided to me. **I understand that any insurance applied for will not take effect unless and until Combined Insurance Company of America approves my application. If coverage cannot be issued as applied for under the rules of the Company, I authorize Combined Insurance Company of America to issue reduced benefits and adjust premiums to match the coverage issued.** I authorize my employer to deduct the premiums for this insurance from my earnings (unless the coverage for which I am applying allows for alternate methods to pay insurance premiums).

In applying for this coverage, I represent and affirm that the information which I have given as recorded on this Enrollment Form is true and complete to the best of my knowledge and belief.

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 such person to criminal and civil penalties.

X _____ City: _____ State: TX Date: _____
Signature of Employee

I, the authorized agent, have on the date of application recorded the information as given to me by the Employee.
Signature of Licensed Agent _____ Code # ACUA

REMARKS OR SPECIAL REQUESTS FOR CONVERSION OR POLICY CHANGE

Form No. 114159

Individual Automatic Premium Collection Agreement and Authorization

COMBINED INSURANCE.

Company Name: FIRST RESPONDERS BENEFIT TRUST

Employee Name: _____

Email: _____ **Phone:** _____

I, the individual who is signing below, hereby authorize Combined Insurance Company of America ("Combined"), to initiate electronic debit entries or to effect a change by any other commercially accepted method, to my checking account (as shown below) in the financial institution named below (hereinafter called Depository). I specifically authorize Depository to debit my account on a monthly basis to pay premiums for the insurance for which I have applied today. This authority is to remain in full force and effect until Combined and Depository have each received written notification from me of its termination. I understand that such notification from me must be given with sufficient time and in such manner as to afford Combined and Depository a reasonable opportunity to act on it.

I also authorize Combined to change the amount of my debit: (1) to correct clerical errors in the initial premium calculation for the above selected coverage(s) and (2) to reflect changes in premium resulting from Combined's underwriting actions, any changes in coverage I may request, and any automatic premium increase that may be required under the terms of my policy(ies). These changes in the amount of my debit are to be made only at the direction of Combined and such change(s) does not require any other subsequent or additional authorization by me.

I understand that if premiums are not paid within the grace period under the subject policy(ies), as in the event withdrawals are dishonored, the policy(ies) will terminate. However, certain life insurance policies may contain nonforfeiture provisions and/or automatic premium loan provisions, which may extend coverage for a period of time. The specific provisions of each policy will govern.

Depositor Name: _____
(Please Print)

Depositor Signature: _____ _____
(Signature must be the same as on file at the bank/financial institution.) (Date)

Preferred draft date of each month: ☐ Draft Amount $ ☐

TYPE OF COVERAGE

Complete the information below or attach a voided check.

Name of Bank

City & State of Bank

Routing (ABA) Number (9 digits)

Account Number

Account Type

Checking