



Hospital Indemnity Insurance

Enrollment Form for AFA Members & Their Families

Underwritten by
Monumental Life Insurance Company, Cedar Rapids, IA

Name: _____

Address: _____

City/State/Zip: _____

Send the Enrollment Form to:
P.O. Box 1341, Valley Forge, PA 19482-9946

MEMBER'S INFORMATION	Social Security Number: - -	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth (m/d/y): / /	Daytime Phone Number: ())	Age: _____

Plan Selection (check one):

- | | | | | |
|--------------|------------------------------|------------------------------|------------------------------|------------------------------|
| Member Only: | <input type="checkbox"/> C-1 | <input type="checkbox"/> D-1 | <input type="checkbox"/> E-1 | <input type="checkbox"/> F-1 |
| Spouse: | <input type="checkbox"/> C-2 | <input type="checkbox"/> D-2 | <input type="checkbox"/> E-2 | <input type="checkbox"/> F-2 |
| Child: | <input type="checkbox"/> C-3 | <input type="checkbox"/> D-3 | <input type="checkbox"/> E-3 | <input type="checkbox"/> F-3 |

If applying for child coverage, please provide the following information for each child to be insured.

Names _____	Date of birth (m/d/y) _____
_____	_____
_____	_____

METHOD OF PAYMENT	Please complete.
<input type="checkbox"/> Bill me* <input type="checkbox"/> Quarterly <input type="checkbox"/> Semiannually <input type="checkbox"/> Annually <input type="checkbox"/> Automatically debit my checking account <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semiannually <input type="checkbox"/> Annually <small>(Please submit a check for the first quarter. This will be the account that is debited for future payments.)</small>	
<input type="checkbox"/> Automatically charge my <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semiannually <input type="checkbox"/> Annually Credit Card # _____ Exp. Date _____ Signature _____	
*Initial quarterly payment must be sent with application unless you have chosen the charge option above.	

I hereby enroll for Hospital Indemnity coverage as provided by Monumental Life Insurance Company. I understand that my insurance coverage will be effective on the first day of the month following receipt of my Enrollment form and initial premium. I also understand that conditions for which I have been medically treated or advised during the 12 month period immediately prior to the effective date of my insurance are not covered until 12 months have elapsed without treatment or I have been insured 24 months (12 months in SC), whichever is less. I acknowledge I have received, read and understand the disclosures.

AR, CO, DC, KY, LA, ME, NM, OH and OK 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 or confinement in prison.

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 of insurance or statement of claim containing any material 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.

NJ Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Member's signature:	Today's date:
Spouse's signature (if applying):	Today's date: