American Sentinel Insurance Company

417 Walnut Street Harrisburg, PA 17101

ENROLLMENT FORM

Please Print or Type All Answers

Applicant's Full Name: Last First MI	__ Male __ Female	__ Single __ Divorced __ Married __ Widowed __ Legally Separated
Applicant's Home Address Street City County State Zip Code		
Social Security No.	Date of Birth	Home Phone Number Area Code ( )
Employer's Name	Date of Hire:______________ Effective Date: ______________	Daytime Phone Number Area Code ( )
Address		Group Number
City County State Zip Code		Location of Employment
Beneficiary	Relationship to you	

IF DEPENDENT COVERAGE IS REQUESTED, LIST ALL ELIGIBLE DEPENDENTS

Full name (first, last, middle initial)	Date of Birth (MM/DD/YY)	Age	Male Female	Social Security No.	If a dependent child is 19 but less than 25 years of age, is he or she a full-time college student or disabled?
Spouse (full name):			__ Male __Female		
Child (full name)			__ Male __Female		__ Full-time Student __ Disabled
Child (full name)			__ Male __Female		__ Full-time Student __ Disabled
Child (full name)			__Male __Female		__ Full-time Student __ Disabled

MEDICAL PLAN *Select the plan in which you are enrolling*	_____Platinum _____Gold _____ Silver *Note: Discount Vision is included with each medical plan.*	Monthly Rate ______________

The coverage for which you are applying includes a Pre-existing limitation which states: We will not pay for a condition for which you, your spouse or covered dependent has received medical treatment, care or advise within 6 months before being covered under this policy. This Pre-existing limitation does not apply if:

a) you, your spouse or covered dependent has received no such treatment, care or advise for that condition for 6 straight months after being covered;
b) coverage has been in effect for 12 months; or
c) the condition is a pregnancy.

This Pre-existing limitation can be reduced by the period of time you, your spouse or dependents were previously insured under a prior plan , if coverage under this plan if effective within 63 days of termination of your prior plan.

I hereby apply for coverage indicated. I understand this application is subject to approval by American Sentinel Insurance Company and/or its reinsurers, and any coverage provided is also subject to the terms of agreement and/or contracts issued to me. Any persons or organizations, or any government agency having provided health care services to me, or any person named on this application or attachments to this application, either prior to or during the period of the contract, is authorized to furnish to American Sentinel Insurance Company, and/or its reinsurers any information or records related to any claims submitted. "Any person 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 act, which is a crime and subject to criminal and civil penalties." I verify that statements made in this application are true and correct.

Signature ____ Date ________________________