



FAX COMPLETED FORM TO 1-888.583.3110

The Insurance Shop/NAWP Enrollment Form

Pay Frequency Weekly Bi-Weekly Bi-Weekly Monthly

Employer Name _____ Group Number _____ Payroll Company _____ Effective Date _____

Member (Last, First, M.I.)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Date of Birth	Date Of Marriage
Spouse (Last, First, M.I.)	<input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.	Date of Birth	

Date of hire _____ Average hours worked per week _____ Annual Salary _____ Occupation _____ Employee ID _____

Home address _____ Work phone/ext. _____

City _____ State _____ Zip Code _____ Home phone _____

Child(ren) name	Date of birth	Gender	Full time student	Child(ren) name	Date of birth	Gender	Full time student
_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number _____				Social Security Number _____			
Child(ren) name _____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child(ren) name _____		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No
Social Security Number _____				Social Security Number _____			

Primary Beneficiary: (Last, First, M.I.) _____ Relationship: _____

Contingent Beneficiary: (Last, First, M.I.) _____ Relationship: _____

Member will be the beneficiary for any spouse and/or child(ren) coverage

Monthly Rates Listed Below

TransChoice Plus® Limited Benefit Medical Coverage Underwritten by Transamerica Life Insurance Company, Cedar Rapids, IA

Please circle the plan you want to enroll in:

SILVER	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee & Family
GOLD	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee & Family
DIAMOND	Employee Only	Employee + Spouse	Employee + Child(ren)	Employee & Family

Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)? Yes No
 If "Yes", List name(s) _____, who will be excluded from coverage.

DENTAL: TransSmile® Underwritten by Transamerica Life Insurance Company, Cedar Rapids, IA **TERM LIFE: Please call for your applicable rate.**

	Basic Premium	Preferred Premium
Employee Only	<input type="checkbox"/> \$15.05	<input type="checkbox"/> \$22.17
Employee plus Spouse	<input type="checkbox"/> \$28.28	<input type="checkbox"/> \$42.53
Employee plus Child(ren)	<input type="checkbox"/> \$34.98	<input type="checkbox"/> \$44.59
Employee & Family	<input type="checkbox"/> \$51.91	<input type="checkbox"/> \$69.11

VISION: Spectera Underwritten by United Healthcare Insurance Company; United Healthcare Insurance Company of New York; Unimerica Insurance Company, Inc.

	Premium
Employee Only	<input type="checkbox"/> \$6.93
Employee plus Spouse	<input type="checkbox"/> \$13.23
Employee plus Child(ren)	<input type="checkbox"/> \$13.86
Employee & Family	<input type="checkbox"/> \$21.37

APPLICANT'S STATEMENTS AND AGREEMENTS:

I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached. I understand that 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. I also understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class of employees; b) I must have satisfied the employer waiting period; c) the employer group must have met the insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively at work, and for my dependents, they must not be disabled, on the effective date (according to the insurer's rules); and f) the first months premium must have been received by the underwriting company at its administration office. **Lastly, I understand that completion of this enrollment form in no way implies that I will be accepted for coverage.**

Signed in (City/State) _____ This _____ Day of (Month/Year) _____

Member's signature _____ Spouse's Signature (if applicable) _____

Licensed Representative's Name _____ Signature _____ Agent # _____