MADISON NATIONAL LIFE INSURANCE COMPANY, INC.

PO Box 5008 Madison, WI 53705

Contract Site:

EMPLOYEE ENROLLMENT FORM FOR LARGE GROUP HEALTH INSURANCE

COVERAGE INFORMATION	
Enrollment Type:	❒ New Coverage ❒ Change/Modification to Existing Coverage ❒ Open Enrollment ❒ Special Enrollment*

**Proof of eligibility for special enrollment will be required*

EMPLOYER INFORMATION
Employer Name:
Group Number if known:

EMPLOYEE INFORMATION			
Employee Name:			
Social Security number:	Date of Birth:	Current Age:	Sex: ❒ M ❒ F
Address:		City:	
County:	State:		ZIP Code:
Mailing Address (if different):		City:	
County:	State:		ZIP Code:
Home Phone:	Email:		❒ Home ❒ Work
What is your job title at your current employer:		Work Phone:	
What was your first day of full-time employment:		How many hours, on average, do you work each week?	
Compensation status: ❒ Hourly		Employee Status: ❒ W**2**	
Are you covered by Worker's Compensation? ❒ Yes ❒ No			
Are you (check one): ❒ Single ❒ Legally Separated ❒ Divorced ❒ Widow or Widower			
❒ Married ❒ Common Law * ❒ Civil Union* ❒ Domestic Partnerships*			
** A common law, civil union, or domestic partnership certification may be required*			
Are you on Cobra or State Continuation? ❒ Yes ❒ No	Start Date:	Stop Date:	

TYPE OF HEALTH INSURANCE COVERAGE
Please select the type of health insurance coverage for which you are applying: ❒ Employee Only ❒ Employee & Spouse ❒ Employee & Child(ren) ❒ Employee & Family

DEPENDENT COVERAGE INFORMATION

Please list all dependents to be covered. If you need additional space, please attach a separate sheet of paper and attach it to the enrollment form.

Name: (First, MI, Last)	Sex	Social Security #:	Relationship:	Disabled	Birth Date (MM/DD/YYYY)
	❒M ❒F		Spouse/Partner		
	❒M ❒F		❒Child ❒Step Child ❒Adopted ❒Other	❒ Yes ❒ No	
	❒M ❒F		❒Child ❒Step Child ❒Adopted ❒Other	❒ Yes ❒ No	
	❒M ❒F		❒Child ❒Step Child ❒Adopted ❒Other	❒ Yes ❒ No	
Dependent address if different than Employee:					

CURRENT HEALTH INSURANCE COVERAGE

Please provide the below requested information if You or your spouse/partner, or your dependent child(ren) listed in this enrollment form have health insurance:

Name of Person	Insurance Carrier Name Carrier Phone Number	Plan Name Group Number Subscriber ID#	Effective Date of Coverage (MM/DD/YYYY)	Termination Date of Coverage (MM/DD/YYYY)	Type of Coverage (see key below)

Type of Coverage Key: G = Group Comprehensive Major Medical; I = Individual Comprehensive Major Medical; M = Medicare; MC = Medicaid; MS = Medicare Supplement; H = Hospital Coverage Only; V = Vision Coverage Only; D = Dental Coverage Only; O = Other _____

TERMS AND CONDITIONS

I acknowledge that I have read all sections of this Employee Enrollment Form for Large Employer Group Health Insurance Coverage (Enrollment Form), and I represent on behalf of my eligible family dependents and myself that the answers contained in this Enrollment Form are complete and accurate. I understand and agree that neither my employer nor any insurance producers have any authority to waive my complete answer to any question, agree to insurability, alter any contract, or waive any other rights or requirements.

I hereby enroll for insurance coverage for myself and for my eligible family dependents listed. On behalf of my eligible family dependents and myself, I agree to all of the terms and conditions of the group contract issued to my employer. I agree that no insurance coverage will be effective until the date specified by Standard Security Life Insurance Company of New York, after this Enrollment form has been accepted.

When applicable, I authorize my employer to deduct premium contributions from my earnings to be applied to my share of the cost of insurance coverage.

I agree to any applicable group contract provisions for the resolution of disagreements and disputes. Please refer to the provisions in the group health insurance certificate of coverage.

I understand that I may request a copy of this Enrollment Form. I agree that a photographic copy of this Enrollment Form shall be as valid as the original. A legible facsimile signature shall have the same force and effectiveness as the original. This document will become a part of the contract when coverage is approved and issued.

Full-Time Employment: I understand that one of the requirements for eligibility on the effective date and for continued eligibility under the plan is that I am actively at work and employed full-time (according to State guidelines) at my employer's place of business.

Benefit Availability: I understand that insurance coverage under this plan begins with a specific effective date of coverage applicable to me and/or my covered dependents and coverage ends on the date in which premium due has not been paid or the last day of the month eligibility ends, subject to the Continuation of Coverage provision. I understand if I or any covered dependents attempt to utilize the benefit plan or prescription drug card when insurance coverage is no longer effective under the policy, I will be personally responsible for those expenses and can be billed by the providers or insurance company for those services.

U.S. Legal Resident: I understand that the insurance coverage under this plan is available for United States residents and benefits are not payable for medical expenses incurred outside of the United States, except as described in the group insurance certificate of coverage in the provision for emergency care while traveling.

FRAUD WARNING

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines, confinement in prison and/or denial of insurance benefits.

_____ _____

Signature of Employee (and parent if applicant is under 18) Date Signed

☐ Initial Enrollment/Employee
☐ Newly Hired Employee
☐ Special Enrollment

MADISON NATIONAL LIFE INSURANCE COMPANY OF NEW YORK

SECURIGUARD, INC.

Enrollment Application

Group Limited Benefit Health Insurance

Contract Site

Please Print or Type

Name (Last) (First) (MI)	Gender	Date of Birth MM/DD/YY	Social Security No.
	☐ M ☐ F	/ /	- -

Address	City	State	Zip	Home Phone
				( ) -

Married: Y / N Email Address:

Policyholder Name	Group Number	Eligibility Status	Date of Hire/Retirement	Business Phone
Challenge Unlimited, Inc.		☐ Salaried Employee ☐ Hourly Employee	/ /	( ) -

Avg Weekly Hours	Earnings	Job Title	Dept. or Branch
	$ ☐ Hourly ☐ Annual	PT / FT	

Life Insurance Information

(Underwritten by Reliance Standard Life Insurance Company)

Have you used tobacco products in the last 12 months? ☐ Yes / ☐ No; Spouse? ☐ Yes / ☐ No

Please write the name of your Beneficiary (ies) their relationship to you (Cannot be self): Last Name, First, Middle Initial:

Name:_____ Relationship:_____ %

Name:_____ Relationship:_____ %

Name:_____ Relationship:_____ %:

If you do not provide beneficiary information, your beneficiary will be the first of the following living persons:
1. Your spouse 2. Your natural and adopted children, equally 3. Your parents, equally 4. Your brothers and sisters, equally.
If none of the above persons are living, then We will pay the benefit to Your estate.

COVERAGE ELECTION: ☐ Self ☐ Self & Spouse ☐ Self & Child (ren) ☐ Self & Family

If you are electing Self only coverage, **DO NOT FILL OUT THE REST OF THIS SECTION.** If your dependents have a different last name, then you must submit a marriage certificate, birth certificate or other information to prove dependency.

Date of Marriage:_____

☐ Check this box if your Spouse is also employed by the company

LIST ALL DEPENDENTS TO BE COVERED. DOCUMENTATION IS NEEDED FOR ADOPTED/FOSTER/STEP CHILDREN OR SPOUSES WITHOUT THE SAME SURNAME.

Name (Last, First, MI)	Date of Birth MM/DD/YY	Gender	Social Security No.	Relationship
	/ /		- -	Spouse
	/ /		- -	Child
	/ /		- -	Child
	/ /		- -	Child
	/ /		- -	Child

I hereby declare that I am in an Eligible Class of the Policyholder indicated above and that I work at or from the employment location indicated. All information given by me on this form at Standard Security Life Insurance Company of New York's request is true and complete and is offered to Madison National Life Insurance Company of New York as inducement to grant insurance. I understand that the Group Limited Benefit Health Plan includes Outpatient Prescription Drug insurance coverage underwritten by Fidelity Security Life Insurance Company, Kansas City, MO and Life insurance coverage underwritten by Reliance Standard Life Insurance Company.

_____ _____

Applicant Signature Date

SECURIGUARD, INC.

Federal Employees

Scheduled Benefits Primary Care Dependent Option / Class IV Major Medical Plan

Payroll Deduction and Benefit Election Form 2014/15

Election Period: September 1, 2014 through August 30, 2015

LAST NAME:_____ FIRST:_____

SSN: ___-___-___ JOB SITE:_____

DATE OF BIRTH:___/___/___ ❒ M ❒ F DATE OF HIRE:___/___/___

OPTIONAL/VOLUNTARY BENEFITS – Paid through 26 Employee Payroll Deductions per Calendar Year

Please check off your desired benefit election(s). You and any elected Dependent(s) will be covered on the first day of the month following the month in which all payroll deductions for the intended month of coverage have been made. For example, if SECURIGUARD, INC. begins deducting in the payroll period starting September 1, 2014, you and any elected Dependent(s) will be covered starting October 1, 2014. Please note that in no event will the effective date of coverage for the Dependent(s) be set prior to that of the Employee.

BENEFITS	**COST PER BI-WEEKLY PAYROLL**
Scheduled Benefits Primary Care Dependent Option	
Add Spouse	❒ $ 63.90
Add Child(ren)	❒ $ 35.90
Add Family	❒ $ 85.50
Major Medical Dependent Option	
Add MM Spouse	❒ $ 278.22
Add MM Child(ren)	❒ $ 210.29
Add MM Family	❒ $ 477.34
Decline Dependent Coverage	❒ $ 000.00

* Please note if you have made a major medical dependent election and loss of Class IV eligibility occurs due to a reduction in hours, your election will automatically transfer to the Primary Care Dependent Option, unless COBRA is elected.

I hereby authorize my employer, SECURIGUARD, INC., to redirect the above portion of my salary to the SECURIGUARD, INC. Health and Welfare Plan for the coverage elected above. If my payroll deduction is taken pre-tax, I understand that my pre-tax election(s) must remain in effect for the full plan year unless a change in life-status occurs which qualifies under Section 125 of the Internal Revenue Code as a permissible basis for discontinuing my coverage election. If my payroll deduction is taken post-tax, I may discontinue my optional coverage during the plan year with the understanding that I may not re-elect the discontinued coverage until the next open enrollment period. Deductions shall continue from year to year unless I direct, 30 days prior to the coverage anniversary, SECURIGUARD, INC. to discontinue or alter the deductions.

I also acknowledge that I have been given the opportunity to enroll in the optional/voluntary benefits of the SECURIGUARD, INC. Health and Welfare Plan and that my election above or lack thereof, reflects my intention. If no dependent coverage is elected, I understand that I will not have the option to enroll my dependents in any part of the Health and Welfare Plan until the next open enrollment period, unless a change in life-status occurs which qualifies under Section 125 of the Internal Revenue Code as a permissible basis for adding the affected Dependent(s).

SIGNATURE:_____ DATE:_____