SUBSCRIBER APPLICATION

SET SEG
School Insurance Specialists
415 W. Kalamazoo St. • Lansing, MI 48933
1-800-292-5421 • Fax 517-482-4181

DISTRICT NAME	
ACCOUNT #	EFFECTIVE DATE

SUBSCRIBER

SOCIAL SECURITY NO. — —	NAME (LAST) (FIRST) (INITIAL)	BIRTH DATE MO. DAY YR.	MARITAL STATUS ☐ SINGLE ☐ MARRIED	SEX ☐ M ☐ F
ADDRESS - NUMBER STREET	CITY	STATE	ZIP CODE	
JOB TITLE/OCCUPATION	HOURS WORKED/WEEK	ANNUAL SALARY	EMPLOYMENT DATE (REQUIRED)	☐ NEW HIRE ☐ RE-HIRE

DEPENDENTS

NAME (FIRST) LAST NAME (IF DIFFERENT)	SOCIAL SECURITY OR MEDICAL #	DO YOU HAVE OTHER HEALTH INSURANCE?		BIRTH DATE MO / DAY / YR	SEX		CHECK IF APPLICABLE	
		YES	NO		M	F	AGE 19-25	DISABLED
SPOUSE	MANDATORY FOR SPOUSE						☐	☐
CHILD							☐	☐
CHILD							☐	☐
CHILD							☐	☐
CHILD							☐	☐

GROUP PLANS

MEDICAL INSURANCE PLAN ☐ ONE-PERSON ☐ TWO-PERSON ☐ FAMILY

GROUP DENTAL ☐ YES ☐ NO ☐ EMPLOYEE ☐ EMPLOYEE & DEPENDENT(S)

GROUP VISION ☐ YES ☐ NO ☐ EMPLOYEE ☐ EMPLOYEE & DEPENDENT(S)

GROUP LONG-TERM DISABILITY: ☐ YES ☐ NO

GROUP LIFE INSURANCE: ☐ YES ☐ NO (AMOUNT) $_____ GROUP DEPENDENT LIFE (if available) ☐ YES ☐ NO

OPTIONS

BASIC LIFE AND AD&D $5,000: ☐ (MUST be selected to choose other optional coverage.)

HOSPITAL CONFINEMENT INDEMNITY INSURANCE (CHECK COVERAGE DESIRED)
☐ SELF ONLY ☐ FAMILY
☐ SELF & SPOUSE
☐ SELF & CHILD(REN) $_____A DAY

SHORT-TERM DISABILITY INCOME INSURANCE
WEEKLY BENEFIT DESIRED $_____
BENEFITS COMMENCE ON ☐ 8TH DAY ☐ 29TH DAY

LONG-TERM DISABILITY INCOME INSURANCE
MONTHLY BENEFIT $_____
☐ OPTION A ☐ OPTION B

SHORT-TERM DISABILITY/LTD COORDINATED PLAN:
BENEFIT DURATION_____WEEKLY BENEFIT_____

DEPENDENT TERM LIFE INSURANCE
☐ YES ☐ NO
$2,000 ON SPOUSE AND EACH ELIGIBLE CHILD TOTAL MONETARY CONTRIBUTION FOR ALL DEPENDENTS IS $1.48

SURVIVOR INCOME INSURANCE
☐ YES ☐ NO
INCLUDES SURVIVING SPOUSE AND DEPENDENT CHILDREN. EXCLUDES SPONSORED DEPENDENTS.

OTHER INSURANCE

ARE YOU OR ANY FAMILY MEMBER COVERED UNDER ANOTHER GROUP INSURANCE PROGRAM(S) ☐ NO ☐ YES — *PLEASE COMPLETE BELOW*

IF YOU HAVE NAMED A CHILD, ABOVE, WHOSE BIRTH PARENTS ARE DIVORCED OR SEPARATED, IS THERE A COURT ORDER STATING WHICH PARENT IS RESPONSIBLE FOR PROVIDING HEALTH INSURANCE? *(PLEASE ATTACH A COPY OF THE COURT ORDER)* ☐ YES ☐ NO WITH WHOM DOES THE CHILD RESIDE? ☐ FATHER ☐ MOTHER

NAME OF SUBSCRIBER	SOCIAL SECURITY NO.	DATE OF BIRTH	EMPLOYER

MEDICAL	DENTAL	VISION
☐ FAMILY ☐ SINGLE	☐ FAMILY ☐ SINGLE	☐ FAMILY ☐ SINGLE
NAME OF INSURANCE CO.	NAME OF INSURANCE CO.	NAME OF INSURANCE CO.
EFFECTIVE DATE	EFFECTIVE DATE	EFFECTIVE DATE

ARE YOU OR ANYONE NAMED ON THIS APPLICATION COVERED BY MEDICARE? ☐ YES (COMPLETE FORM #CN3040) ☐ NO

BENEFICIARY

PRIMARY BENEFICIARY:_____RELATIONSHIP:_____

IF LIVING; OTHERWISE,

SECONDARY BENEFICIARY:_____RELATIONSHIP:_____

SIGNATURE

I HAVE READ AND UNDERSTAND THE CONDITIONS ON THE REVERSE SIDE OF THIS FORM.

APPLICANT SIGNATURE X DATE

WHITE — SET SEG CANARY — INSURED PINK— SCHOOL

Please read the following information before completing the reverse side of this application.
THE INFORMATION ON THIS FORM AND THE FOLLOWING CONDITIONS ARE PART OF MY CONTRACT WITH SET INC. AND/OR ITS DESIGNATED UNDERWRITING INSURANCE COMPANY(IES).
I am applying for coverage under my group or association contract with SET Inc. Coverage begins on the date determined by SET Inc. and/or its underwriters. When SET Inc. accepts my application I and covered members of my family are bound by the terms of the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

Proof of eligibility: I agree to provide proof of my dependents' eligibility for coverage when requested by SET Inc. or the appropriate insurance company(ies) underwriting my coverage(s).

Authorization: I appoint my group or association to handle all matters of coverage. They may forward any agreed deductions for coverage from my wages. **I am responsible for giving notice to my group or association of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, births, or death of someone covered under the policy.** I authorize the appropriate insurance company(ies) underwriting my coverage(s) and/or my physician(s) to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage, and for other purposes necessary to fulfill the underwriter's (s') contractual and statutory obligations.

Release of information: SET Inc. does not require your Social Security number, however, your group or association, Medicare, Medicaid and others do require it. SET Inc. will release information about you only when:

- You authorize it in writing.
- When it must be released to process a claim (e.g. to another insurance company). Upon your written request, SET Inc. will tell you when the information was sent.

Underwriting Insurance Companies

Health Insurance
Supplemental Medical Insurance
Basic Life, Accidental Death and Dismemberment Insurance
Group Medical Options
Dental Insurance
Vision Insurance
Group Long-Term Disability Insurance
Group Life, Accidental Death and Dismemberment Insurance

These benefits may be underwritten and/or administered by one or more of several Insurance Companies or Third-Party Administrators, depending on the type of coverage and carrier selected by your employer. Please contact SET Inc. or your employer regarding questions related to what specific coverage and/or carrier your employer has selected.