Unimerica Insurance Company
Association Administrative Address:
P.O. Box 17828 • Portland, Maine 04112-8828

Group Hospital Income Insurance Enrollment Form
PIA Services Group Insurance Fund
Group Policy Number: 1062

Section 1: Member/Employee Information

1. Member/Employee Name:_____

2. Billing Address:_____ City:_____ State:_____ Zip:_____

3. Sex: ☐ Male ☐ Female 4. Daytime Phone #:_____

5. Date of Birth: _____/_____/_____ 6. Social Security Number:_____

7. Your PIA Membership affiliation:
   - ☐ Individual proprietors, partners, corporate officers, limited liability partners and managers of member Agencies who are principally engaged in the business of the Member Agency and who maintain current membership status in the National Association of Professional Insurance Agents
   - ☐ Trustees of PIA Services Group Insurance Fund who maintain current membership status in the National Association of Professional Insurance Agents
   - ☐ Persons employed as executive directors, department heads, division heads, or senior staff of the National Association of PIA, a local PIA affiliate, or PIA Services, Inc.
   - ☐ Trust manager of PIA Services Group Insurance Fund
   - ☐ Licensed employees of Member Agencies
   - ☐ Independent Producers who:
     a) work exclusively for a Member Agency;
     b) maintain current membership status in the National Association of Professional Insurance Agents;
     c) receive from the Member Agency a monthly commission which, when combined with any draw against commission, equals an amount not less than minimum wage times 150 hours; and
     d) are certified by the Member Agency as working at least 20 hours per week
   - ☐ A Member Agency
   - ☐ PIA Services Group Insurance Fund
   - ☐ National Association of Professional Insurance Agents or its local affiliates
   - ☐ PIA Services, Inc.

Please list below the eligible dependents that you wish to insure. The member or employee must be insured to cover dependents. If you need more space, list additional children on a separate sheet of paper and send it to us with your enrollment form.

Dependent	**Name**	**Date of Birth**
Spouse		
Child(ren)		

Section 2: Plan Selection for Group Hospital Income Coverage

1. Daily Benefit Amount: Member/Employee $:_____ Spouse $:_____ Children $:_____
   ($50 to $200 Daily Benefit Amount in increments of $50.)

   The Spouse's Daily Benefit Amount will be the same as the member's/employee's.
   A Child's Daily Benefit will be 50% of the member's/employee's. If the Daily Benefit Amount You select is greater than $100, it will reduce to $100 at age 65.

2. Maximum Benefit Period: 500 Days

3. At Home Recovery Lump Sum: ☐ $1,000 ☐ $2,000
   ☐ Member/Employee Only ☐ Member/Employee & Spouse ☐ Member/Employee & Family

Section 3: Agreement and Authorization

I understand and agree that coverage will not take effect until the first day of the month after my enrollment form and first premium for the required amount are received by the Plan Administrator. I understand that during the first 12 months of my insurance or of my dependent's insurance, losses incurred for pre existing conditions may not be covered. PreExisting Condition means any Injury or Sickness, including Mental Illness or Substance Abuse, for which I or my dependent(s) were diagnosed by, received or required Treatment, including medications and supplies from, a Physician or other licensed practitioner of the healing arts, within the 12 month period prior to the coverage effective date. Conditions which result from the same or related Injury or Sickness; or from any aggravations of the Injury or Sickness are considered to be the same Injury or Sickness for the purpose of defining a PreExisting Condition. PreExisting Conditions Limitations are explained in detail in the Certificate of Insurance.

I understand that the hospital income coverage is supplemental health insurance and not a substitute for hospital or medical expense insurance, health care service plans, or major medical expense insurance. 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 is guilty of a crime and may be subject to fines and confinement in prison.

Member's/Employee's Signature: _____ Dated:_____

Retain a photocopy of this enrollment form for your records and return the original to:

Lockton Affinity, LLC

P.O. Box 410679 • Kansas City, MO 64141-0679 • Phone: 800-336-4759 •
EMAIL: pia@locktonaffinity.com

Underwritten on Policy Form AAH5001A(UIC) by: Unimerica Insurance Company
Association Administrative Address: P.O. Box 17828 • Portland, Maine 04112-8828