FedAdvantage
FILLING THE GAPS IN YOUR BENEFITS

Accident Insurance Enrollment Form

Dennis Stephens, CLU
AllFeds.com
888-330-1790

SECTION 1

☐ New ☐ Change (check each section applicable) _______________ (enter certificate # if making a change)	Policy/Group #:**681091 / DEN1**

SECTION 2 ☐ Change **EMPLOYER INFORMATION**

Do you work in the Federal Judiciary? ☐ Yes ☐ No	Department (see reverse for code)	Agency (Executive Branch use ONLY)

For Federal Judiciary Use Only

Circuit:	District of:	Court:	Are you a judge? ☐ Yes ☐ No

SECTION 3 ☐ Change **PERSONAL INFORMATION**

Social Security Number	Name (last, first, middle initial)		
☐ Male ☐ Female ☐ Single ☐ Married	Street Address		
Date of Birth / /	City State Zip Code		
Home Telephone	Work Telephone	Date of Hire / / Month Day Year	E-mail Address

SECTION 4 ☐ Change **COVERAGE INFORMATION**

I am paid: ☐ bi-weekly (26 pay periods per year) ☐ monthly (12 pay periods per year)	***Please confirm your eligibility:*** I am an active full-time employee of the United States Federal Government working at least 20 hours per week. ☐ Yes ☐ No Please specify number of hours worked per week _______________
Plan Coverage	☐ Employee ☐ Employee + Spouse ☐ Employee + Child(ren) ☐ Family

SECTION 5 ☐ Change **BENEFICIARY INFORMATION**

Primary Beneficiary Name Last Name First Name	Relationship of Beneficiary	Social Security Number / Tax ID# (if trust or charity)	
Street Address	City	State	Zip
Contingent Beneficiary Name Last Name First Name	Relationship of Beneficiary	Social Security Number	
Street Address	City	State	Zip

SECTION 6 ☐ Change **DEPENDENT COVERAGE INFORMATION**

Last Name	First Name	M.I.	Gender	Date of Birth	Social Security Number
SPOUSE:					
CHILDREN:					

SECTION 7

I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the group policy and summarized in any communication materials provided me and/or the certificate issued to me. I understand that the effective date of insurance for myself is subject to my being actively at work on that date. I request arrangement for the issuance of Group Accident Insurance, underwritten by The Hartford Life and Accident Insurance Company, for which I am or may become eligible and authorize deductions of the required contributions from my earnings. My signature below signifies my agreement with the statements and authorization above.

NOTE: ANY PERSON WHO KNOWINGLY OR WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY OR WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFIENMENT IN PRISON.

Employee Signature	Date

After completion, **sign and date the form on where indicated.**
Make a copy for your records and **Fax to Dennis Stephens, CLU at 888-334-5809**