



ACE American Insurance Company
Philadelphia, PA 19106



Mail or fax completed form to:
Towers Affinity Benefit Services
4510 Cox Road, Suite 111
Glen Allen, VA 23060
Fax – (804) 273-9989

Enrollment Form for Group Insurance

Group's Name:
Ice Skating Institute

Requested Effective Date:

Your Last Name First Name Middle Initial

Social Security No.

Your Street Address

City State Zip Code

Home Phone

Date of Birth

Your Email Address

Sex:

- Male
 Female

Marital Status:

- Single Married
 Divorced Widowed
 Legally Separated

Is this:

- New Coverage
 Change in Coverage

Plan Option(s) Chosen:

- TMed+1
 TMed+2
 TMed+4
 Dental Option

Coverage Type:

- Member Only
 Member & Spouse
 Member & Child(ren)
 Member & Family

Payment Mode*:

- Monthly
 Quarterly
 Semi-Annual
 Annual

Payment Method*:

- Direct Bill (checks payable to:
Towers Affinity Benefit Services
 Visa or MasterCard
(complete authorization on back)

***Note that a \$3 administrative fee per billing/credit card transaction will be charged.**

Do you have an eligible spouse? Yes No

How many eligible children do you have? _____

Provide the following information for all eligible dependents to be insured under the plan:

Spouse's Full Name

Date of Birth

M F

Age Social Security No.

Child's Full Name

Date of Birth

M F

Age Social Security No.

Child's Full Name

Date of Birth

M F

Age Social Security No.

Child's Full Name

Date of Birth

M F

Age Social Security No.

Beneficiary for Accidental Death & Dismemberment Benefit:

Your Beneficiary: _____

Relationship: _____

You will be the beneficiary for Dependents.

I have read the Limited Accident & Sickness Insurance Plan enrollment material and accept the terms and conditions of the coverage outlined in it. I understand the Limited Accident & Sickness Insurance Plan does not provide Major Medical or Comprehensive Medical coverage. I have read the enrollment material and understand my coverage is subject to the terms and conditions of the policy issued to Ice Skating Institute. I understand my coverage will go into effect on the date stated in the material only if I am in active service on that date. If I am not in active service on that date, my coverage will go into effect on the date I return to active service. If I have elected coverage for my dependents, their coverage will not go into effect prior to my effective date and they must be in active service on the effective date. I understand that hospital and surgery benefits available under the plan are not payable for any pre-existing condition until after coverage has been in effect for six months (waived if enrolled by October 1, 2010). I affirm that I and my eligible dependents have not been Hospital Confined more than once in the 12 months preceding enrollment and are not scheduled for a Hospital Confinement at the time of enrollment.

To the best of my knowledge and belief, all information I have provided is true and complete. I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, the Insurance Company will ask me for written authorization to disclosed information about me.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

Member's Signature

Date Signed

Credit Card Authorization

(Please print)

Name _____

Address _____
Street City State Zip Code

Mailing Address _____
(If different than above) Street or PO Box City State Zip Code

Visa MasterCard Name on Credit Card _____

Credit Card Number _____ Expiration Date _____

Telephone Number _____ Fax Number _____

I authorize Affinity Group Underwriters / Towers Affinity Benefit Services to bill my VISA / MASTERCARD for insurance plan(s) provided by ACE American Insurance Company.

This authorization is to remain in force until Affinity Group Underwriters / Towers Affinity Benefit Services has received written notification from me of its termination in such time and in such manner as to afford Affinity Group Underwriters / Towers Affinity Benefit Services reasonable opportunity to act upon it.

Member's Signature

Date Signed



Enrollment Form for Supplemental Benefits

Mail or fax completed form to:
Towers Affinity Benefit Services
4510 Cox Road, Suite 111
Glen Allen, VA 23060
Fax – (804) 273-9989

Group's Name:
Ice Skating Institute

Requested Effective Date:

Your Last Name First Name Middle Initial

Social Security No.

Your Street Address

City State Zip Code

Home Phone

Date of Birth

Your Email Address

- | | | | |
|---------------------------------|--|--------------------------------------|--|
| Sex: | Marital Status: | Payment Mode*: | Payment Method*: |
| <input type="checkbox"/> Male | <input type="checkbox"/> Single <input type="checkbox"/> Married | <input type="checkbox"/> Monthly | <input type="checkbox"/> Direct Bill (make checks payable to Towers Affinity Benefit Services) |
| <input type="checkbox"/> Female | <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed | <input type="checkbox"/> Quarterly | <input type="checkbox"/> Visa or MasterCard |
| | <input type="checkbox"/> Legally Separated | <input type="checkbox"/> Semi-Annual | (complete authorization on back) |
| | | <input type="checkbox"/> Annual | |

***Payment Mode & Payment Method must be the same as selected for Limited Medical and/or Dental. Note that a \$3 administrative fee per billing/credit card transaction will be charged.**

The following Supplemental Benefits are available through Citizens Security Life. Please indicate which, if any, you want to continue, add or terminate.

VISION

I want to:

- Continue
- Add
- Terminate

Persons to cover:

- Member Only
- Member + One
- Member + Family

Monthly Cost:

- Member Only - \$4.90
- Member + One - \$8.90
- Member + Family - \$12.90

HOSPITAL INDEMNITY

I want to:

- Continue
- Add
- Terminate

Persons to cover:

- Member Only
- Member + One
- Member + Family

Monthly Cost:

- Member Only - \$15.17
- Member + One - \$28.90
- Member + Family - \$38.00

SHORT TERM DISABILITY

I want to:

- Continue
- Add
- Terminate

Persons to cover:

- Member Only

Monthly Cost:

- Member Only - \$22.75

TERM LIFE & AD&D

I want to:

- Continue
- Add
- Terminate

Persons to cover:

- Member Only
- Member + One
- Member + Family

Monthly Cost:

- Member Only - \$7.75
- Member + One - \$10.25
- Member + Family - \$12.75

Provide the following information for all eligible dependents to be insured under the plan(s):

_____ Spouse's Full Name	_____ Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	_____ Age	_____ Social Security No.
_____ Child's Full Name	_____ Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	_____ Age	_____ Social Security No.
_____ Child's Full Name	_____ Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	_____ Age	_____ Social Security No.
_____ Child's Full Name	_____ Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	_____ Age	_____ Social Security No.

Beneficiary for Term Life and Accidental Death & Dismemberment Benefit through Citizens Security Life:

Your Beneficiary: _____ Relationship: _____

You will be the beneficiary for Dependents.

To the best of my knowledge and belief, all information I have provided is true and complete. I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, the Insurance Company will ask me for written authorization to disclosed information about me.

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Member's Signature

Date Signed

Credit Card Authorization

(Please print)
Name _____

Address _____
Street City State Zip Code

Mailing Address _____
(If different than above) Street or PO Box City State Zip Code

Visa MasterCard Name on Credit Card _____

Credit Card Number _____ Expiration Date _____

Telephone Number _____ Fax Number _____

I authorize Affinity Group Underwriters / Towers Affinity Benefit Services to bill my VISA / MASTERCARD for insurance plan(s) provided by Citizens Security Life Insurance Company.

This authorization is to remain in force until Affinity Group Underwriters / Towers Affinity Benefit Services has received written notification from me of its termination in such time and in such manner as to afford Affinity Group Underwriters / Towers Affinity Benefit Services reasonable opportunity to act upon it.

Member's Signature

Date Signed