



**Limited Accident & Sickness Insurance
For Members Of Ice Skating Institute**



An Affordable Alternative To Comprehensive Major Medical

Highlights

- ◆ **Affordable Monthly Premiums**
- ◆ **Convenient Payment Methods - Direct Billing or Debit/Credit Card Transactions**
- ◆ **No Health Questions or Physical Exams Required to Qualify**
- ◆ **Choose from 3 Plan Designs**
- ◆ **6 Month Pre-Existing Condition Limitation* - Applies to Hospital & Surgery Benefits Only**
- ◆ **Includes PPO Access – No Penalties for Using Non-Network Providers**
- ◆ **Provides Limited Benefits for the Most-Used Medical Services – Can Help You and Your Family Obtain Medical Treatment Before a Health Condition Becomes More Serious**
- ◆ **First Dollar Coverage – No Deductibles or Co-Insurance**
- ◆ **No Coordination of Benefits**
- ◆ **Benefits are Assignable**
- ◆ **Includes Access to Prescription Drug Discounts & 24 Hour Nurse Hotline**

<u>Benefits</u>	<u>Choose from the following plan designs:</u>		
	<u>TMed+1</u>	<u>TMed+2</u>	<u>TMed+4</u>
Doctor Office Visits (5 visits)	\$50/visit	\$20 co-pay	\$20 co-pay
Outpatient Lab & X-ray (Plans 1 & 2: 3 visits; Plan 4: 4 visits)	\$75/visit	\$100/visit	\$125/visit
Wellness Visits (Adults-1 visit; Children through age 4-3 visits)	\$50/visit	\$20 co-pay; up to \$75/visit	\$20 co-pay; up to \$125/visit
Hospitalization			
Regular Confinement (30 days)	\$250/day	\$350/day	\$500/day
ICU Confinement (10 days)	\$500/day	\$700/day	\$1,000/day
Mental & Nervous Confinement (10 days)	\$125/day	\$175/day	\$250/day
Substance Abuse Confinement (10 days)	\$125/day	\$175/day	\$250/day
Skilled Nursing Facility Confinement (20 days)	\$125/day	\$175/day	\$250/day
Surgery	\$500	\$1,000	\$2,000
Anesthesia (up to 25% of surgery benefit)	\$125	\$250	\$500
Emergency Room (1 visit for Sickness; 2 visits for Injury)	\$100/visit	\$250/visit	\$250/visit
Vision Care			
Annual Eye Exam	\$25	\$25	\$50
Frames & Lenses or Contacts (every 2 Plan Years)	\$50	\$50	\$100
AD&D	Included	Included	Included
Member - \$5,000 / Spouse - \$2,500 / Child(ren) - \$1,000			

Co-pay benefits are subject to UCR and any maximum amount shown.

All benefits, except AD&D, are subject to Plan Year maximums as shown above.

*“Plan Year” means the 12 consecutive month period of September 1 through August 31 of each year.

Additional Features Included In Each Plan

Access to Beech Street PPO.

Go to any doctor or hospital—but— by using a doctor or hospital in the Beech Street PPO network, the charge may be lower. Please note that this insurance plan may not cover the entire bill. Members will be responsible for any balance. ID cards will include information on finding a participating doctor or hospital.

Prescription Drug Discount Card.

Discounts of 16-73% are available on generic and brand name prescription drugs. Just visit a participating pharmacy and pay the lesser of the pharmacy’s usual and customary fee or the RegenceRx contract rate. No claim form required.

24/7 Nurseline.

Round-the-clock access to detailed health information and the ability to speak with a live health professional.

These are discounts and services available through contracted vendors; they are not insurance.

Monthly Premium

	TMed+1	TMed+2	TMed+4
Member	\$74.00	\$111.00	\$159.00
Member & Spouse	\$152.00	\$233.00	\$334.00
Member & Child(ren)	\$119.00	\$180.00	\$259.00
Family	\$202.00	\$312.00	\$447.00

Exclusions and Limitations

The following is a brief list of the exclusions and limitations for the insurance plan. It is not a complete list. A complete list is available from the agent and will be included in the Certificate of Insurance issued to each participating member.

- | | |
|---|---|
| <ul style="list-style-type: none"> ❖ Occupational injury or sickness ❖ Dental, eye or vision care (except as provided) ❖ On or off-road use of a motorized vehicle which does not require vehicle licensing (for AD&D only); operating a motorized vehicle without a valid driver's license ❖ Mental Illness or Alcohol or Drug Abuse (except as provided for inpatient confinements) ❖ Claims incurred while intoxicated, under the influence of any drugs or while committing or attempting to commit a felony | <ul style="list-style-type: none"> ❖ Self-inflicted injury, suicide or suicide attempt ❖ War, military service, riot ❖ Cosmetic surgery or experimental treatment ❖ Pre-existing conditions* in the first 6 months of coverage (hospital & surgery benefits only) ❖ Elective abortion ❖ Treatment rendered outside of the US except for a medical emergency |
|---|---|

Prescription drugs are not covered expenses under the insurance plan. Employees and their dependents pay the lesser of the pharmacy's usual and customary fee or the contract rate. Typical savings range from 16 to 73% based on the drug type (brand or generic) and the participating pharmacy filling the claim. No claim forms are required. Prescriptions for 30-day supplies can be filled at more than 52,000 participating pharmacies nationwide including all of the national chains and over 90% of independent pharmacies. For additional savings, there are also two mail order pharmacies available for 90 day supplies. Visit www.regencerx.com to learn more. Please note this is not insurance.

*A pre-existing condition is any condition occurring in the 6 month period prior to becoming insured under this plan for which treatment was received or recommended or with symptoms which would cause an ordinarily prudent person to seek treatment. Treatment includes the taking of prescription drugs unless the condition is controlled. **The 6 month pre-existing condition limitation is waived for all members under the prior Zurich policy who enroll by October 1, 2010.**

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit ACE USA from providing insurance, including, but not limited to, the payment of claims.

The limited accident & sickness plan is underwritten by ACE American Insurance Company, part of the ACE Group of Companies, Rated A+ (Superior) by A.M. Best Company for financial strength and operative performance.

Eligibility & Enrollment – Professional or Affiliate members of ISI may enroll within 30 days of the date of their membership or during any annual open enrollment period. Members' dependents (spouse or children under age 26) may also be enrolled. Coverage is effective the first day of the month following the date the enrollment form is processed provided the member and dependent(s) are actively at work on that day. For enrollees who are not employed, "actively at work" means the person is able to engage in substantially all of the usual activities of a person in good health of like age and sex and is not confined in a hospital or rehabilitation or rest facility. In addition, enrollees may not have been hospital confined more than once in the 12 months prior to enrollment and may not be scheduled for a Hospital Confinement at the time of enrollment.

IMPORTANT! *The Limited Accident & Sickness Insurance Plan is not comprehensive major medical insurance.* It is a package of benefits and services plan that pays benefits for the most used types of medical services and is designed to help take care of the basic medical care needs of insured members and their families. This plan pays in addition to any other insurance in force. Please note, also, that **this plan is not a Medicare Supplement plan.**

This information is a brief description of the important features of the insurance plan. It is not a contract of insurance. Terms and conditions of coverage will be set forth in the group policy underwritten by ACE American Insurance Company and issued to Ice Skating Institute. The group policy is subject to the laws of the State of Texas. Please keep this material as a reference and review your group policy carefully once you receive it.



**Dental Indemnity Insurance
For Members of
Ice Skating Institute**

An Affordable Dental Plan



You may elect coverage under the Dental Indemnity Plan even if you are not covered under one of the Limited Accident & Sickness Insurance Plans. If you do elect coverage under both plans, you must cover the same family members under both plans.

Dental Schedule of Benefits

Category:	Plan pays:	Category:	Plan pays:
Type 1: Preventive & Diagnostic		Type 5: Periodontics (\$500 Lifetime Maximum)	
a. Oral exams, including prophylaxis	\$ 36.00	a. Tissue grafts or bone surgery	\$ 96.00
b. Bitewings, per film	\$ 4.80	b. Gingivectomy (per quadrant), periodontal scaling, periodontal splinting, root planing	\$ 60.00
c. X-ray, panoramic or cephalometric	\$ 36.00	c. Gingival curettage (per quadrant)	\$ 36.00
d. Sealants / topical fluoride	\$ 10.20	d. Gingivectomy (per tooth)	\$ 24.00
e. Space maintainers	\$108.00		
Type 2: Major Restorative		Type 6: Oral Surgery	
a. Crowns, bridges & dentures	\$180.00	a. Surgeries Level 1 (ex. Removal of exostosis)	\$120.00
b. Pre-fabricated crowns	\$ 60.00	b. Surgeries Level 2 (ex. Removal of impacted tooth)	\$ 66.00
c. Crown build-up procedures	\$ 48.00	c. Surgeries Level 3 (ex. Simple extraction)	\$ 36.00
Type 3: Minor Restorative		Type 7: General Anesthesia and IV	
a. Fillings	\$ 42.00	a. IV, first half hour general, each additional 1/4 hour general	\$ 72.00
b. Crown, bridge and denture repairs	\$ 24.00		
c. Relining or rebasing dentures	\$ 60.00	Type 8: Orthodontia (Lifetime Maximum)	\$500.00
Type 4: Endodontics			
a. Root canals, apicoectomies	\$192.00		
b. Root amputation	\$ 96.00		
c. Therapeutic pulpotomy, retrograde fillings, apexification, hemisection	\$ 48.00		

All benefits, except Orthodontia, are subject to the Plan Year maximum of \$1,000; in addition, periodontic care is subject to a \$500 lifetime maximum. Orthodontic care is subject to a \$500 lifetime maximum.

“Plan Year” means the 12 consecutive month period from September 1 through August 31 of each year.

Benefits for Types 2, 5, 6a, 7 and 8 are subject to a 12 month waiting period. *The 12 month waiting period will be waived for all members insured under the prior Zurich policy who enroll by October 1, 2010.*

For more information, contact:
CT Benefits
(888) 612-3335

MONTHLY PREMIUMS

Member Only	\$19.00
Member & Spouse	\$37.00
Member & Child(ren)	\$53.00
Family	\$71.00

Exclusions and Limitations

The following is a brief list of the exclusions and limitations for the insurance plan. It is not a complete list. A complete list is available from the agent and will be included in the Certificate of Insurance issued to each participating member.

- ❖ Services or supplies not shown on the Schedule of Benefits
- ❖ Services or supplies for Types 2, 5, 6a, 7 or 8 which are incurred during the first 12 months of coverage
- ❖ Any condition covered under Workers' Comp or similar law
- ❖ Drugs, except antibiotic injectibles administered during treatment
- ❖ TMJ; temporary bridge or denture
- ❖ Any treatment beginning prior to the effective date of coverage
- ❖ Charges resulting from changing from one provider to another during treatment
- ❖ Athletic mouth guards; replacement of retainers
- ❖ Treatment rendered outside of the US

This insurance does not apply to the extent that trade or economic sanctions or regulations prohibit ACE USA from providing insurance, including, but not limited to, the payment of claims.

This coverage is underwritten by ACE American Insurance Company, part of the ACE Group of Companies, Rated A+ (Superior) by A.M. Best Company for financial strength and operative performance.

Enrollment – Professional or Affiliate members of ISI may enroll within 30 days of the date of their membership or during any annual open enrollment period. Members' dependents (spouse or children under age 26) may also be enrolled. Coverage is effective the first day of the month following the date the enrollment form is processed provided the member and dependent(s) are actively at work on that day. For enrollees who are not employed, "actively at work" means the person is able to engage in substantially all of the usual activities of a person in good health of like age and sex and is not confined in a hospital or rehabilitation or rest facility.

IMPORTANT! *The Dental Indemnity Insurance Plan is not comprehensive dental insurance. It pays benefits based on the Schedule of Benefits for services available under the plan. It is designed to help take care of the basic dental care needs of insured members and their families. This plan pays in addition to any other insurance in force.*

This information is a brief description of the important features of the insurance plan. It is not a contract of insurance. Terms and conditions of coverage will be set forth in the group policy underwritten by ACE American Insurance Company and issued to Ice Skating Institute. The group policy is subject to the laws of the State of Texas. Please keep this material as a reference and review your certificate carefully once you receive it.



HOSPITAL INDEMNITY COVERAGE

If the insured or covered dependent is admitted to a hospital as an inpatient for a period of at least 24 hours then this coverage will provide the following benefits:

- Lump sum benefit of \$1000 for one confinement annually
- \$100 daily benefit for each day confined up to 100 days

Premium	Weekly	Monthly
Employee	\$3.51	\$15.20
Employee + 1	\$6.67	\$28.90
Family	\$8.77	\$38.00

SHORT TERM DISABILITY COVERAGE

- Weekly benefit for up to 6 months
- 50% of base pay (including reported tips, but no overtime) up to \$150
- 14 day waiting period unless hospitalized then benefits begin immediately

Monthly Premium	
Employee	\$22.75

TERM LIFE COVERAGE

- \$25,000 life insurance benefit with matching accidental death and dismemberment benefit
- Eligible dependents can sign up for
 - Spouse \$10,000
 - Children over 7 months \$5,000

The employee's face amount reduces to 50% at age 55, to 25% at age 60, and to 10% at age 65. The spouse's face amount reduces at the same rate, but based on the ee's age. These rates include AD&D for employees.

Plan design and benefits provided by Citizens Security Life Insurance Company and administered by CT Benefits and Davis Vision Plan.

Premium		Weekly	Monthly
Employee		\$1.79	\$7.75
Employee + 1		\$2.37	\$10.25
Family		\$2.94	\$12.75



VISION COVERAGE	
Eye Examination	Once every 12 months
Materials	One complete set of spectacle lenses or contact lenses (in lieu of eyeglasses) every 12 months and frames every 24 months.

In-Network Benefits

	Co-payment*
Eye Examination with Dilation	10
Materials	
Eyeglasses (lenses and frames)	25
Contact Lenses	
Soft Standard Daily Wear	25
Disposable/Planned Replacement (initial supply)	25
Medically Necessary Contact Lenses - (Keratoconus)	25

Note this benefit is subject to prior approval - the Covered Person or attending Provider must send a completed request to Davis Vision for medically necessary contact lenses for correction of Keratoconus before the lenses are dispensed. Any amount due over the Allowance for such lenses is the Covered Person's responsibility. If the required approval is not obtained, benefits will not be paid for such lenses and the entire charge will be your responsibility.

* Does not apply to Optional In-Network items or Covered Expenses received from an Out-of-Network Provider.

**Frames other than Davis Vision's Fashion, Designer or Premier Collections will be paid up to a maximum of \$60. The balance, if any, is the Covered Person's responsibility. If the Covered Person chooses a frame from the Designer or Premium Collection there is an additional co-payment; See below

*** Contact lenses other than Standard, Soft Daily Wear or Disposable Planned Replacement contact lenses will be paid up to a maximum of \$50. The balance, if any, is the Covered Person's responsibility.

Fashion Plan

Eyewear from Davis Vision's Fashion Collection. In-Network Providers will have complete exclusive Tower Collection (of Davis Vision frames). In addition, you and your Covered Dependents may also select any of the Optional In-Network Items shown below, including frames from Davis Vision's Designer or Premier Collection. All Optional In-Network Items are subject to applicable co-payment.

Optional In-Network Items	Co-payment
Designer Frames	Included
Premium Frames	25
Glass Grey #3 prescription lenses	Included
Fashion, sun and gradient tinted plastic lenses	Included
Scratch Resistant Coating	20
Ultra Violet Coating	12
Anti-Reflective Coating	
Standard Types	35
Premium Types	48
Progressive Addition Multifocal Lenses	
Standard Types	50
Premium Types	90
Intermediate Vision Lenses	30
Blended Segment Lenses	20
Polycarbonate Lenses	* 30
High Index Lenses	55
Polarized Lenses	75
Photogrey Extra (photosensitive) glass lenses	20
Plastic Photosensitive lenses	65

*no no-payment for children up to age 19 or monocular patients



VISION COVERAGE

Out-of-Network Benefits

	Allowance*
Eye Examination with Dilation	40
Materials	
Frames	45
Lenses	
Single Vision	40
Bifocal	60
Trifocal	80
Lenticular	80
Contact Lenses	105

* Unless the examination and materials are medically necessary, any charges in excess of Allowance is your responsibility.

Medically Necessary Contact Lenses- (Keratoconus) 225

Note this benefit is subject to prior approval - the Covered Person or attending Provider must send a completed request to Davis Vision for medically necessary contact lenses for correction of Keratoconus before the lenses are dispensed. Any amount due over the Allowance for such lenses is the Covered Person's responsibility. If the required approval is not obtained, benefits will not be paid for such lenses and the entire charge will be your responsibility.

Low Vision Program

Comprehensive Evaluation	Once every 60 months (including four follow up visits)
Maximum Per Evaluation	300
Maximum per Follow-up visit	100
Low Vision Aids	600
Lifetime Maximum for all Aids	1200

Note this program is available both in-and out-of-network and is subject to prior approval - the Covered Person or the attending Provider must send a completed request to Davis Vision prior to the initial evaluation. Once approved, a Covered person is eligible for a comprehensive low vision evaluation and four follow-up visits every 60 months up to the maximum evaluation and visits shown above. Any amount due over the allowances above for an evaluation, follow-up visits or aids is the Covered Person's responsibility. If the required approval is not obtained, no benefits will be paid for any such evaluation, follow-up visits or aids - the entire charge for such services will be your responsibility

Monthly Premium	Weekly	Monthly
Employee	\$1.13	\$4.90
Employee + 1	\$2.05	\$8.90
Family	\$2.98	\$12.90



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.

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 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