Employee ID: _____

Return completed form to Human Resources
Upload to MedHub | Attach to HR Help Desk Request

NEW HIRE - EIT/RESIDENT

ENROLLMENT FORM FOR GROUP ACCIDENT INSURANCE
FOR THE EMPLOYEES OF U.W. HOSPITAL & CLINICS

Underwritten by Zurich American Insurance Company
Policy Number: **GTU 2584087**

Reason for Submitting Form:
☐ Elect coverage ☐ Change Coverage ☐ Cancel Coverage ☐ Beneficiary Change
☐ Other:

Employee Information:			
Last Name:	First Name:	M.I.:	Occupation:
Social Security Number:	Employee ID:	Sex:	Date of Birth:
Spouse Name:		Spouse Occupation:	
Beneficiary Designation & Relationship:		The beneficiary for **Spouse** and **Dependent Child(ren)** is the employee named on the enrollment form.	

Coverage Information:		
Plan (check one): ➔	☐ Plan I – Employee Only	☐ Plan II – Family Coverage
Coverage Amount (check one):	Employee Plan Monthly Premium	Family Plan Monthly Premium
☐ $50,000	$1.70	$2.40
☐ $100,000	$3.40	$4.80
☐ $150,000	$5.10	$7.20
☐ $200,000	$6.80	$9.60
☐ $250,000*	$8.50	$12.00
☐ $300,000*	$10.20	$14.40
☐ $350,000*	$11.90	$16.80
☐ $400,000*	$13.60	$19.20
☐ $450,000*	$15.30	$21.60
☐ $500,000*	$17.00	$24.00

* Rate Basis: Monthly, Per $1,000 of Covered Benefit ($0.034/$1,000 for Employee Only, $0.048/$1,000 for Family Coverage). Benefit amounts in excess of $250,000 may not exceed ten (10) times your base annual pay excluding overtime, bonuses, commissions and special compensation.

Signature Section:
☐ I elect the coverage above and authorize the monthly insurance premiums to be deducted from my earnings.
☐ I have been given the opportunity to apply for this insurance but I do not desire to participate at this time.
☐ I elect to cancel my coverage.

Your Signature:	Date:

For Employer Use Only:	
Date Received:	Effective date of coverage/change:
Assistant Initials:	PS Entry Date:

(09/2018)