



KeySelect Fidelity Insurance

PRIMARY HEALTH CHOICE INDEMNITY COVERAGE
MEMBER ENROLLMENT FORM
Fidelity Security Life Insurance Company • Kansas City, MO

Administered by: Key Benefit Administrators, Inc.
P. O. Box 1989, Fort Mill, SC 29716-1989
Ph. 866-387-3402 Fax 866-225-9507
Email: KeySelect.enroll@keybenefit.com



POLICYHOLDER: United Associations of America Group Insurance Trust

Policy Number: LM-123

MEMBER INFORMATION (Please print in ink) [] New Enrollment [] Change Request EFFECTIVE DATE:
Member Name (Last, First, M.I.) [] Male [] Female Date of Birth
Home Address City State Zip
Home Phone # Work Phone # Social Security #
Beneficiary (Last, First, M.I.) Relationship: Plan Name: Primary Health Choice
DEPENDENT INFORMATION (Complete only for Dependents to be covered) [] Additional Dependents (Attached)
Name (Last, First, M.I.) Social Security # Relation Gender Date of Birth Full Time College Student
Spouse: [] Male [] Female / / [] Yes [] No
Child: [] Male [] Female / / [] Yes [] No
Child: [] Male [] Female / / [] Yes [] No
Applicant will be the beneficiary for spouse (or equivalent, as defined by governing state law)
COVERAGE (check one) [] Member Only [] Member & Spouse [] Member & Child(ren)* [] Member & Family
*Dependent Children who are eligible for the Ohio Healthy Start Program are not eligible for Primary Health Choice.
Mode of Monthly Payment (If employer is facilitating payroll deductions ALL members must elect Payroll Deduction as mode of payment)
[] Payroll Deduction Monthly Premium \$ Group Name Facilitating Payment:
[] Credit Card Payment* (Choose one): [] MasterCard [] Visa [] Discover 3-Digit Security Code**:
Initial Amount \$ Name (as on card)
Card Number Expiration Date / /
Signature of Cardholder ▶
*\$5.00 Monthly Processing Fee Applies. **Security Code is located on the back of the card in the signature strip
ENROLLEE'S STATEMENT AND AGREEMENTS
I acknowledge and agree that the insurance plan in which I am enrolling has not been presented as and is not a Major Medical policy. I elect to participate in the above plans. I hereby affirm that the information on this form is true and complete as of the date I signed this Enrollment Form. I understand the Policy's eligibility requirements and that all insured persons must continue to meet those requirements in order to maintain coverage. I understand that this insurance will not become effective until I am notified of acceptance under the Policy and that I should not cancel other coverage (if any) until notified by the Company or its authorized representative of such acceptance. I understand that insurance for any person enrolling for coverage will not become effective if such person is hospital confined or unable to perform his or her regular and customary activities, and that no such person's insurance will become effective before my insurance is effective. I understand that by enrolling in this insurance plan I am also becoming a member of the United Associations of America Group Insurance Trust. I understand that this insurance is not an employer health plan and I certify that (a) premiums are being paid by me as a personal expense with no portion of my premium paid by the Policyholder; and (b) this insurance does not qualify as an employer health insurance plan for any purpose, including a tax deduction. Individuals not meeting this certification are not eligible for this plan.
I hereby authorize any insurance company, organization, employer, hospital, physician, surgeon, or pharmacist to release any information requested with respect to this coverage and any claims as a result.
I authorize the required payroll deductions associated with my elected coverage and the coverage of my Dependents, if any. I reserve the right to revoke this deduction at any time with written notification to the Company and my employer.
Any person, who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
Member Signature: Date:
Submitting Agent Name: Submitting Agent ID: