SHELTERPOINT

Enrollment/Change Form

ShelterPoint Life Insurance Company
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Garden City, NY 11530
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Phone: 800.365.4999 (516.829.8100)
www.shelterpoint.com

Type of Coverage	☐ Dental	☐ Vision	☐ LTD	☐ AD&D	☐Accidental Injury	☐Hospital Cash	
Policy No.							
Policyholder (Employer):							
☐ New Enrollment	☐ New Employee ☐ Open Enrollment ☐ P/T to F/T Status ☐ Rehire						Date:
☐ Change Enrollment	☐ New Address ☐ Name Change, Previous Name:						Date:
☐ Add ☐ Change ☐ Cancel Spouse/Domestic Partner and/or Dependent							Date:

A. Employee Information

Name (Last, First)			Gender ☐ M ☐ F	Date of Birth
Street Address			Date of F/T Hire	
City	State	ZIP	Hours worked per week	
Social Security No.			Annual Salary $	
Job Title	Home Phone		Work Phone	

B. Spouse/Domestic Partner & Dependent Coverage (*If more space is needed, attach extra copies.)*

Spouse/Domestic Partner's Name (Last, First)	Date of Birth	Gender	Request to	Reason
		☐ M ☐ F	☐ Add ☐ Cancel	☐ Marriage ☐ Divorce ☐ Death

	Child's Name (Last, First)	F/T Student	Date of Birth	Gender	Request to	Reason
1		☐ Y ☐ N		☐ M ☐ F	☐ Add ☐ Cancel	☐ Birth ☐ Adoption ☐ Death ☐ other
2		☐ Y ☐ N		☐ M ☐ F	☐ Add ☐ Cancel	☐ Birth ☐ Adoption ☐ Death ☐ other
3		☐ Y ☐ N		☐ M ☐ F	☐ Add ☐ Cancel	☐ Birth ☐ Adoption ☐ Death ☐ other

C. Beneficiaries for LTD – Benefits are payable to estate of the deceased unless otherwise indicated.

☐ Add beneficiary ☐ Change existing beneficiary to individual(s) below: (*If more space is needed, attach extra copies.)*

Name (Last, First)	Social Security No.	Marital Status	Occupation	Benefit %	Relationship
Name (Last, First)	Social Security No.	Marital Status	Occupation	Benefit %	Relationship
Contingent Beneficiary(ies): If the beneficiary(ies) above are not living, then pay:					
Name (Last, First)	Social Security No.	Marital Status	Occupation	Benefit %	Relationship

C. Beneficiaries for AD&D – Benefits are payable to estate of the deceased unless otherwise indicated.

☐ Add beneficiary ☐ Change existing beneficiary to individual(s) below: (*If more space is needed, attach extra copies.)*

Name (Last, First)	Social Security No.	Marital Status	Occupation	Benefit %	Relationship
Name (Last, First)	Social Security No.	Marital Status	Occupation	Benefit %	Relationship
Contingent Beneficiary(ies): If the beneficiary(ies) above are not living, then pay:					
Name (Last, First)	Social Security No.	Marital Status	Occupation	Benefit %	Relationship

D. Participation/Waiver	
☐ Request to Participate: I hereby request to participate in the program. I agree to contribute as required.	
☐ Waiver of Insurance (not participating)	I do not wish to participate. I understand that if I wish to participate at a later date, my benefits may be denied or reduced. Declined for: ☐ Self: ☐ Dental ☐ Vision ☐ LTD ☐ AD&D ☐ Hospital Cash ☐ Accidental Injury ☐Spouse/Dom. Partner: ☐ Dental ☐ Vision ☐ LTD ☐ AD&D ☐ Hospital Cash ☐ Accidental Injury ☐Dependent: ☐ Dental ☐ Vision ☐ LTD ☐ AD&D ☐ Hospital Cash ☐ Accidental Injury Reason: ☐ Spouse/Domestic Partner's Plan ☐ Not interested ☐ Other Plan, please specify:

LTD: ☐ I certify that I am not currently disabled and I am performing all duties required for my job on a full-time basis.

I UNDERSTAND THAT THIS IS ACCIDENT-ONLY INSURANCE AND HOSPITAL INDEMNITY INSURANCE. ACCIDENT-ONLY INSURANCE DOES NOT PROVIDE COVERAGE FOR SICKNESS. THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. I ACKNOWLEDGE THAT I HAVE COMPREHENSIVE HOSPITAL, SURGICAL AND MEDICAL HEALTH INSURANCE (MINIMUM ESSENTIAL COVERAGE).

If you have questions about the benefits provided by this coverage, please contact us at 1-800-365-4999.

***NOTICE:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.*

The information provided above is true and correct to the best of my knowledge and belief.

Signature _____ Date _____