



**Group Long Term Care  
Employee Enrollment Form**

If any parts of Sections 1 through 4 are blank, we cannot process your enrollment form.

**SECTION 1 – EMPLOYEE INFORMATION**

Applicant's Name: First, Middle Initial, Last		Date of Birth / /	Sex (M or F)
Applicant's Address: Number and Street		Social Security Number:	
City	State	Zip Code	
Daytime Phone Number ( )	Evening Phone Number ( )	Date of Hire / /	

**SECTION 2 – BENEFIT SELECTIONS**

Select ONE Daily Benefit / Lifetime Maximum:

**5 Year (1,825 days) Plan**

- \$100 Daily Benefit/ \$182,500 Lifetime Maximum
- \$175 Daily Benefit/ \$319,375 Lifetime Maximum
- \$250 Daily Benefit/ \$456,250 Lifetime Maximum

**SECTION 3 – OTHER INSURANCE COVERAGES**

Do you currently have long-term care insurance in force or have you recently applied for such insurance? YES  NO

If yes, please list all such coverages in the space provided below. Indicate if you intend to replace any medical or health insurance coverage, including health care service contract or health maintenance organization with the insurance applied for with this application.

Company Name	Company Address	Policy Number	Is coverage to be replaced?	When
			YES <input type="checkbox"/> NO <input type="checkbox"/>	

**OVER, PLEASE**

## SECTION 4 – EMPLOYEE AUTHORIZATION

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 FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR SUCH VIOLATION.

To the best of my knowledge and belief, the information on this enrollment form is true and complete. I understand that the insurance I have selected for myself will begin on the Certificate Effective Date shown in my Certificate of Insurance provided that I am actively at work on that date with **Bard College**. If I am not actively at work on that date, my insurance will not take effect until the first day of the month after I return and remain actively at work. I understand that actively at work means that I am at my usual place of employment on the effective date of the coverage.

I authorize **Bard College** to make the appropriate **payroll deduction** for the above specified coverage and release other necessary information to the administrators of the program.

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_