



AWA Limited Benefit Health Insurance

Individual Enrollment Form for Group Accident & Sickness Indemnity Insurance

Underwritten by Colonial Supplement Insurance

Please Print

Group Policyholder: **AFFILIATED WORKERS ASSOCIATION** Requested Effective Date _____

Enrollee Name: _____

Enrollee Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: _____ Daytime Phone Number: _____

Gender: Male Female Date of Birth: _____ E-mail Address: _____

Coverage: Enrollee Only

Plan Selection: AWA \$1,500 Monthly Benefit AWA \$3,000 Monthly Benefit

By signing below, I and the individuals named herein are eligible for insurance. I understand that this is not basic health insurance or major medical coverage and it is not intended as a substitute for basic health insurance or major medical coverage and that the coverage will not begin until the effective date shown in the coverage document. I further understand that the coverage will not pay benefits during the Plan Period described below for pre-existing condition I/we currently have or have had in the past. Beginning on the Effective Date, benefits will not be paid for any pre-existing condition until the end of 12-consecutive months. **I authorize Homeland HealthCare to collect any and all premiums due for this coverage.**

Fraud Warning: Any person who knowingly and with intent, defrauds or deceives any insurance company by submitting an application or filing a claim that contains any false or incomplete information, or conceals information for the purpose of misleading, is guilty of insurance fraud, which is a felony and subject to criminal and/or civil penalties.

Enrollee's Signature: _____ Date: _____

Automatic Bank Draft (drafted on the **25th** of the month before the first effective date)

Bank Name: _____

Routing Number: _____

Account Number: _____

Applicant Signature: _____ Date: _____

Agent Name (Please Print): Martin Unger Agent #: 20981

Agent Signature: _____ Date: _____

PAYMENT CALCULATOR	
Monthly Plan Cost	_____
Enrollment Fee	\$ 25.00
TOTAL First	
Month's Payment =	_____

Please Mail Both Application Pages To:

Martin Unger
5070 NW 96th Way
Coral Springs, FL 33076

or Fax To: 1-775-254-2881

Optional Benefits

AWA Short Term Disability Income Protection

underwritten by Colonial Supplemental Insurance

The Affiliated Worker's Disability Income Protection program replaces a portion of your income (up to six months) if you become disabled because of a covered accident or a covered sickness. This income can help you continue paying your mortgage, rent, car payments, household bills, food, clothing, and other necessities.

With this program, you are paid regardless of any other insurance you may have, benefits are paid directly to you, and your coverage is guaranteed renewable to age 70. If you change jobs you can take your coverage with you, and you are covered worldwide for up to 60 days. There is a zero day elimination period for Accident, and a seven day elimination period for Sickness. There must be a 66 2/3 % of verifiable income to qualify for the amount paid.

AWA Short Term Disability Income Protection

Age Band	\$1,500/month	\$3,000/month
17-49	\$65/month <input type="checkbox"/>	\$116/month <input type="checkbox"/>
50-69	\$82/month <input type="checkbox"/>	\$152/month <input type="checkbox"/>

Yes, I would like to enroll in the AWA Disability Income Protection Plan that I marked above.

Signature _____ Date _____