



# SUBSCRIBER APPLICATION

School Insurance Specialists  
415 W. Kalamazoo St. • Lansing, MI 48933  
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DISTRICT NAME
ACCOUNT #

SUBSCRIBER	SOCIAL SECURITY NO.	NAME (LAST)	(FIRST)	(INITIAL)	BIRTH DATE MO. DAY YR.	MARITAL STATUS	<input type="checkbox"/> SINGLE	SEX	<input type="checkbox"/> M
	ADDRESS - NUMBER		STREET	CITY	COUNTY	STATE	<input type="checkbox"/> MARRIED	<input type="checkbox"/> F	
	JOB TITLE/OCCUPATION			HOURS WORKED/WEEK	ANNUAL SALARY	EMPLOYMENT DATE (REQUIRED)	<input type="checkbox"/> NEW HIRE <input type="checkbox"/> RE-HIRE		

DEPENDENTS	NAME (FIRST)	LAST NAME (IF DIFFERENT)	SOCIAL SECURITY OR MEDICAL #	DO YOU HAVE OTHER HEALTH INSURANCE?	BIRTH DATE MO / DAY / YR	SEX	CHECK IF APPLICABLE			
	SPOUSE			<b>MANDATORY FOR SPOUSE</b>	YES	NO	M	F	AGE 19-25	DISABLED
	CHILD								<input type="checkbox"/>	<input type="checkbox"/>
	CHILD								<input type="checkbox"/>	<input type="checkbox"/>
	CHILD								<input type="checkbox"/>	<input type="checkbox"/>
	CHILD								<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL	BASIC GROUP LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (REQUIRED) \$5,000 INCLUDED IN MEDICAL INSURANCE. CHECK HERE IF APPLYING FOR BASIC LIFE ONLY (NO MEDICAL) <input type="checkbox"/>								
	MEDICAL INSURANCE PLAN	<input type="checkbox"/> ONE-PERSON <input type="checkbox"/> TWO-PERSON <input type="checkbox"/> FAMILY <input type="checkbox"/> SPONSORED DEPENDENT					SUBGROUP #		

OPTIONS	GROUP HOSPITAL CONFINEMENT INDEMNITY INSURANCE (CHECK COVERAGE DESIRED)	<input type="checkbox"/> SELF ONLY <input type="checkbox"/> FAMILY	GROUP SHORT-TERM DISABILITY INCOME INSURANCE	WEEKLY BENEFIT DESIRED \$
	GROUP LONG-TERM DISABILITY INCOME INSURANCE	MONTHLY BENEFIT \$	SHORT-TERM DISABILITY/LTD COORDINATED PLAN:	BENEFITS COMMENCE ON <input type="checkbox"/> 8TH DAY <input type="checkbox"/> 29TH DAY
	GROUP DEPENDENT TERM LIFE INSURANCE	<input type="checkbox"/> YES <input type="checkbox"/> NO	\$2,000 ON SPOUSE AND EACH ELIGIBLE CHILD TOTAL MONETARY CONTRIBUTION FOR ALL DEPENDENTS IS \$1.48	GROUP SURVIVOR INCOME INSURANCE

GROUP PLANS	ULTRA-DENT INSURANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO	SUBGROUP #	<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> EMPLOYEE & DEPENDENT(S)
	ULTRA-VISION INSURANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO	SUBGROUP #	<input type="checkbox"/> EMPLOYEE <input type="checkbox"/> EMPLOYEE & DEPENDENT(S)
	GROUP LONG-TERM DISABILITY: <input type="checkbox"/> YES <input type="checkbox"/> NO	SUBGROUP #	
	GROUP LIFE INSURANCE: <input type="checkbox"/> YES <input type="checkbox"/> NO	(AMOUNT)\$	SUBGROUP #

OTHER INSURANCE	ARE YOU OR ANY FAMILY MEMBER COVERED UNDER ANOTHER GROUP INSURANCE PROGRAM(S) <input type="checkbox"/> NO <input type="checkbox"/> YES — PLEASE COMPLETE BELOW					
	IF YOU HAVE NAMED A CHILD, ABOVE, WHOSE BIRTH PARENTS ARE DIVORCED OR SEPARATED, IS THERE A COURT ORDER STATING WHICH PARENT IS RESPONSIBLE FOR PROVIDING HEALTH INSURANCE? (PLEASE ATTACH A COPY OF THE COURT ORDER)			WITH WHOM DOES THE CHILD RESIDE?		
	NAME OF SUBSCRIBER		SOCIAL SECURITY NO.	DATE OF BIRTH	EMPLOYER	
	MEDICAL	NAME OF INSURANCE CO. EFFECTIVE DATE	DENTAL	NAME OF INSURANCE CO. EFFECTIVE DATE	VISION	NAME OF INSURANCE CO. EFFECTIVE DATE
	ARE YOU OR ANYONE NAMED ON THIS APPLICATION COVERED BY MEDICARE? <input type="checkbox"/> YES (COMPLETE FORM #CN3040) <input type="checkbox"/> NO					

BENEFICIARY	PRIMARY BENEFICIARY: _____	RELATIONSHIP: _____
	IF LIVING; OTHERWISE, SECONDARY BENEFICIARY: _____	RELATIONSHIP: _____

SIGNATURE	I HAVE READ AND UNDERSTAND THE CONDITIONS ON THE REVERSE SIDE OF THIS FORM.	
	APPLICANT SIGNATURE <b>X</b>	DATE

Please read the following information before completing the reverse side of this application.

**THE INFORMATION ON THIS FORM AND THE FOLLOWING CONDITIONS ARE PART OF MY CONTRACT WITH SET INC. AND/OR ITS DESIGNATED UNDERWRITING INSURANCE COMPANY(IES).**

I am applying for coverage under my group or association contract with SET Inc. Coverage begins on the date determined by SET Inc. and/or its underwriters. When SET Inc. accepts my application I and covered members of my family are bound by the terms of the policy and this application. I understand that the submission of false or misleading information or the omission of material information on this form may result in rejection of my enrollment or retroactive termination of my coverage.

**Proof of eligibility:** I agree to provide proof of my dependents' eligibility for coverage when requested by SET Inc. or the appropriate insurance company(ies) underwriting my coverage(s).

**Authorization:** I appoint my group or association to handle all matters of coverage. They may forward any agreed deductions for coverage from my wages. **I am responsible for giving notice to my group or association of changes in my status and/or my family's status that affect coverage, such as marriage, divorce, births, or death of someone covered under the policy.** I authorize the appropriate insurance company(ies) underwriting my coverage(s) and/or my physician(s) to obtain the medical records relating to me and my enrolled family members necessary for the coordination of our medical care, administration of my coverage, and for other purposes necessary to fulfill the underwriter's (s') contractual and statutory obligations.

**Release of information:** SET Inc. does not require your Social Security number, however, your group or association, Medicare, Medicaid and others do require it. SET Inc. will release information about you only when:

- You authorize it in writing.
- When it must be released to process a claim (e.g. to another insurance company). Upon your written request, SET Inc. will tell you when the information was sent.

### **Underwriting Insurance Companies**

#### **Health Insurance**

SET group health insurance plans are underwritten by Blue Cross and Blue Shield of Michigan. SET supplemental medical insurance is underwritten by Associated Mutual Hospital Service of Michigan.

**Basic Group Life, Accidental Death and Dismemberment Insurance** is underwritten by Associated Mutual Hospital Service of Michigan.

#### **Group Options**

SET Group Options coverage is underwritten by Associated Mutual Hospital Service of Michigan.

**Ultra-Dent Insurance** is underwritten by Fortis Benefits Insurance Company.

**Ultra-Vision Insurance** is underwritten by Fortis Benefits Insurance Company.

**Group Long-Term Disability Insurance** may be underwritten by Fortis Benefits Insurance Company; UnumProvident Life Insurance Company of America; or Fort Dearborn Life Insurance Company.

**Group Life Insurance** may be underwritten by Fortis Benefits Insurance Company; UnumProvident Life Insurance Company of America; or Fort Dearborn Life Insurance Company.

**SET Inc.** will administer all claims for Supplemental Medical Insurance; Ultra-Dent and Ultra-Vision plans. The underwriting companies will administer claims for all other coverages.