CHUBB

ACE American Insurance Company
(A Stock Company)
Philadelphia, PA 19106

Enrollment Form for Cancer Continuation Coverage

Policy Number PTP N16744712

Instructions:
Policyholder (Fire Department) - Section 1 of this form should be completed and furnished only to persons eligible to continue coverage pursuant to the Class Description shown in the Policy.
Applicant - Within 31 days of termination, complete Section 2 below and mail this form along with a check for the amount of Annual Premium indicated, based on your age, to the address listed below.

Section 1: To be completed by Policyholder's (Fire Department's) representative

Policyholder (Fire Department) Name				
Employee's or Volunteer's Name: Last / First / M.I.				Date of Birth
Home Address – Street		City	State	Zip Code
Home Telephone #	Start Date with Policyholder (Fire Department)	Date of Separation from Policyholder (Fire Department)		
E-mail Address				
Policy #:				
Type	☐ Full-time or Part-time Employee Firefighter ☐ Volunteer Firefighter			
If a Volunteer, are you employed with another Georgia Fire Dept?	☐ Yes – Where: ☐ No Volunteers may not continue coverage under Our plan if they are employed with another Georgia Fire Dept. Any such volunteer should contact their employer to select continuation under their employer's plan.			
Policyholder Signature (employer)		**Title**		**Company Phone #**

Section 2: To be completed by Applicant
(Do not mail this form to insurer until top portion is completed and signed by employer).

Check Age:

Age at date of Continuation	Annual Premium for FT or PT Employees	Annual Premium for Volunteers
☐ 18-24	$34	$33
☐ 25-29	$47	$46
☐ 30-34	$66	$64
☐ 35-39	$99	$96
☐ 40-44	$171	$166
☐ 45-49	$313	$305
☐ 50-54	$567	$556
☐ 55-59	$970	$948
☐ 60-64	$1,652	$1,612
☐ 65-70	$2,665	$2,607
☐ 70+	$4,329	$4,210

Please read and sign:
I accept the insurance elected above.

To the best of my knowledge and belief, all information I have provided is true and complete. I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, the Insurance Company will ask me for written authorization to disclose information about me.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

My signature below certifies that I have read and understand the brochure and agree to accept the terms and conditions stated therein.

Applicant's Signature _____ Date Signed _____

Payment: Please make the premium check payable to: *ACE American Insurance Company – Premium Notice* and remit the Enrollment Form and check to: **ACE American Insurance Co – Dept. CH. 14113, Palatine, IL 60055-4113**