

YOU MUST COMPLETE THIS FORM AND FAX TO (877) 456-4787

Group Name VANGUARD PROFESSIONAL STAFFING		Location		Effective Date	
Member (Last, First, M.I.)		<input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security No.	Date of Birth
Spouse (Last, First, M.I.)		<input type="checkbox"/> Male <input type="checkbox"/> Female		Social Security No.	Date of Birth
Date of hire	Avg hours worked per week	Annual Salary	Occupation	Employee ID	
Home address				Work phone/ext.	
City		State	Zip Code	Home phone	
Child name	Date of birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Full time student <input type="checkbox"/> Yes <input type="checkbox"/> No	Child name	Date of birth
Social Security Number				Social Security Number	
Child name		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	Child name	
Social Security Number		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	Social Security Number	
Primary Beneficiary:(Last, First, M.I.)				Relationship:	
Contingent Beneficiary:(Last, First, M.I.)				Relationship:	
Member will be the beneficiary for any spouse and/or child(ren) coverage					
TransChoice Plus[®] Limited Benefit Medical Coverage			Underwritten by Transamerica Life Insurance Company, Cedar Rapids, IA		
		Silver			Gold
Member Only	<input type="checkbox"/>	\$44.48	<input type="checkbox"/>	\$70.94	
Member plus Spouse	<input type="checkbox"/>	\$73.40	<input type="checkbox"/>	\$123.48	
Member Plus Child(ren)	<input type="checkbox"/>	\$72.52	<input type="checkbox"/>	\$125.00	
Member & Family	<input type="checkbox"/>	\$101.04	<input type="checkbox"/>	\$177.96	
Is anyone proposed for coverage covered by any Title XIX program (e.g. Medicaid)?					Total _____
If "Yes", List name(s) _____, who will be excluded from coverage.					<input type="checkbox"/> Yes <input type="checkbox"/> No
TransSmile[®]			Underwritten by Transamerica Life Insurance Company, Cedar Rapids, IA		
		Bi-Weekly Basic Premium			Bi-Weekly Preferred Premium
Member Only	<input type="checkbox"/>	\$6.95	<input type="checkbox"/>	\$10.23	
Member plus Spouse	<input type="checkbox"/>	\$13.05	<input type="checkbox"/>	\$19.63	
Member plus Child(ren)	<input type="checkbox"/>	\$16.14	<input type="checkbox"/>	\$20.58	
Member & Family	<input type="checkbox"/>	\$23.96	<input type="checkbox"/>	\$31.90	Total _____
CS Vision					
CS Vision Insurance is underwritten by Davis Vision and administered by Citizens Security Life Insurance Company, Home Office: Louisville, KY					
		Bi-Weekly Premium			
Member Only	<input type="checkbox"/>	\$3.66			
Member plus Spouse	<input type="checkbox"/>	\$6.57			
Member plus Child(ren)	<input type="checkbox"/>	\$7.32			
Member & Family	<input type="checkbox"/>	\$10.32			Total _____
APPLICANT'S STATEMENTS AND AGREEMENTS					
<p>I represent that all statements and answers made on or attached to this application are true to the best of my knowledge and belief, and realize that any false statements herein which materially affect the acceptance of the risk or the hazard assumed may result in loss of coverage under the policy/certificate to which this application is attached. I understand that 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 subjects such person to criminal and civil penalties. I also understand that coverage will become effective only after all of the following conditions have been met: a) I must be a member of an eligible class of employees; b) I must have satisfied the employer waiting period; c) the employer group must have met the insurer's minimum participation requirement; d) I must satisfactorily answer all questions on this form; e) I must be actively at work, and for my dependents, they must not be disabled, on the effective date (according to the insurer's rules); and f) the first months premium must have been received by the underwriting company at its administration office. Lastly, I understand that completion of this enrollment form in no way implies that I will be accepted for coverage.</p>					
Signed in (City/State) _____ This _____ Day of (Month/Year) _____					
Member's signature _____			Spouse's Signature (if applicable) _____		
Licensed Representative's Name _____			Licensed Representative's Signature _____ Agent # _____		
<p>If you choose not to enroll in coverage, please sign below. I decline coverage at this time.</p>					
Signed in (City/State) _____ This _____ Day of (Month/Year) _____					
Member's signature _____					