MANSFIELD INDEPENDENT SCHOOL DISTRICT
Guaranteed Acceptance
RETURN THIS COMPLETED APPLICATION TO MANSFIELD I.S.D BENEFITS OFFICE

GROUP HOSPITAL INDEMNITY PLAN
INDIVIDUAL ENROLLMENT FORM

Underwritten by Life Insurance Company of North America (LINA)

Name:

Address:

City, State Zip

☐ PLAN: $150 Per Day – Employee Only

Your Date of Employment:

Your Telephone Number:

Your Date of Birth:

Your Beneficiary:

Relationship:

I understand that my coverage will become effective the first of the month following receipt of my Enrollment Form.

I understand that I am covered immediately for new accidents or new illnesses commencing after the effective date of my insurance coverage. I further understand that I will not be covered for any pre-existing conditions (conditions for which I have received medical advice or treatment, from a licensed health practitioner, within the 12 consecutive months preceding the effective date of my coverage) until I have been covered under the group policy for 12 consecutive months.

Your Signature____

Date____

TER-604854-f (9/09)