**ENROLLMENT / WAIVER FORM**

**THOMAS JEFFERSON NATIONAL ACCELERATOR FACILITY**

***INTERNATIONAL RESEARCH SCIENTISTS***

**ACCIDENT & SICKNESS INSURANCE PLAN**

**October 01, 2022 0 September 30, 2023**

**Policy GLMN01060909**

**YOUR NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(PLEASE PRINT) (Last) (First) (MI)

**ADDRESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(LOCAL) (Street) (City) (State) (Zip)

**ENROLLMENT [ ]** Please **enroll** me and my dependents, if any, in the Accident and Sickness Insurance Plan. I understand coverage will become effective on the later of October 1, 2017, or the date the Enrollment Form and full premium are received by the ACE American Insurance Company or Program Administrator. The coverage dates for my Dependents’ and me will be the same, provided the required premium is paid.

Effective Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Expiration Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Monthly Rates) Participant Spouse Child

Age 40 or less $289.00 $553.00 $337.00, birth to age 19

Age 41 - 49 $345.00 $654.00 (to age 25 if child is full time student)

Age 50 - 59 $434.00 $773.00

Age 60 - 64 $500.00 $914.00

Age 65+ $566.00 $1,082.00

Total Monthly Premium $\_\_\_\_\_\_\_\_\_\_\_ x #months\_\_\_\_ = Total Premium Due $\_\_\_\_\_\_\_\_\_\_\_\_

***Make all checks payable to: ACE American Insurance Company***

DEPENDENT INFORMATION (IF ANY ENROLLED)

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_

**WAIVER [ ]** I wish to **waive** enrollment in the Accident & Sickness Insurance Plan due to the fact that I am

covered by:

Name of Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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.**

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

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DELIVER TO:** Jefferson Lab International Services Office

628 Hofstadter Rd., Suite 2

Newport News, VA 23606