



**ALABAMA STATE EMPLOYEES ASSOCIATION**  
**\$1,000,000 CANCER PROTECTOR PLAN ENROLLMENT FORM**

CA-29B/C  
 188-0603/188-0604  
 76695

**1. PLEASE TYPE OR PRINT IN INK**

Name \_\_\_\_\_  
 Mailing Address \_\_\_\_\_ E-mail address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**2. Please Tell Us About Yourself**

Birth Date (mo/day/yr) \_\_\_\_\_ Sex \_\_\_\_\_ Social Security No. \_\_\_\_\_

**3. Please Choose Your Coverage**

**A. Plan Options**

Silver Option  Platinum Option

**B. I wish to cover (please select one):**

Member Only  Member + Spouse  Family

**C. Fill in below if you wish to cover your spouse and/or dependent children:**

	Name	Social Security No.	Sex	Age	Birth Date
Spouse					
Child					
Child					
Child					

**4. AUTHORIZATION**

I hereby represent that as of the date I signed this application, no person to be insured under this Cancer Plan has had any type of cancer during the past 10 years except \_\_\_\_\_ who is/are to be excluded from coverage under this plan. I understand that no benefits are payable for the first 12 months of coverage for any cancer which first manifests itself within the first 30 days after the individual insured's effective date. I understand any material misstatements or omissions may be used as a basis for rescinding my coverage. This means all claims will be denied and the company's liability will be limited to full refund of premium less any claims previously paid.

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

*Coverage becomes effective on the first day of the month following approval of your completed enrollment form and receipt of your first premium payment during your lifetime.*

A-00682

Policy Form No. M-7000

*Underwritten and Administered by: Fidelity Security Life Insurance Company | Kansas City, Missouri 64111-2406  
 Presented by: Countryman and Smitherman, Inc. • Prattville, Alabama 36066*

**5. PAYROLL DEDUCTION AUTHORIZATION TO ASEA**

I understand that, hereafter, the regular monthly premiums will be deducted from my paycheck.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Date Employed \_\_\_\_\_ Department/Agency \_\_\_\_\_ Division \_\_\_\_\_

Work Phone No. \_\_\_\_\_ Home Phone No. \_\_\_\_\_

**Mail this Enrollment Form in the postage-paid envelope provided to:**  
 ASEA Insurance Office • 110 North Jackson Street • Montgomery, AL 36104  
**Any questions? Call (334) 834-6965 or (800) 252-7063**

## **IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS**

### **This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

### **This insurance duplicates Medicare benefits when it pays:**

- hospital or medical expenses up to the maximum stated in the policy.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include :**

- hospitalization
- physician services
- hospice
- other approved items and services

### **Before You Buy This Insurance**

- Check the coverage in **all** health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.