THE PAUL REVERE LIFE INSURANCE COMPANY, Worcester, MA
Mailing Address: PO Box 100267 Columbia, SC 29202

GROUP HOSPITAL CONFINEMENT INDEMNITY INSURANCE ENROLLMENT FORM

Named Insured Section

Named Insured (First, MI, Last)	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Social Security No.

Home Address – Street	City	State	Zip Code	Employee ID/Payroll No.

Email Address	Home Phone No. Business Phone No.

Date Employed	Occupation/Job Title	Annual Income	Hrs. Worked/ Week	Employee Class

Billing Section

Employer Name	Employer Address (Street-City-State-Zip)	Section/Dept. No.
New York State Business Group	180 E. Main St Patchogue, NY 11772	

Spouse Section

Is your spouse applying for coverage? If yes, provide identifying information below. Yes ☐ No ☐

Name of Spouse (First, MI, Last)	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.

Plan Section

Type of Coverage	Base Plan Code(s)	P = Pre-Tax A = After-Tax	Monthly Premium
☐ Named Insured ☐ Named Insured & Spouse ☐ Named Insured & Dependents ☐ Named Insured, Spouse & Dependents		P ☐ A ☐	

Agreement Section

I understand that the coverage applied for will not pay benefits for any loss incurred during the first 12 months after the issue date for a disease or physical condition that I now have or have had in the past. By applying for the coverage indicated above, I am requesting cancellation of existing Hospital Confinement Insurance with The Paul Revere Life Insurance Company (base plan and all applicable riders) if the coverage applied for is issued. If, for any reason the coverage applied for is not issued, this request for cancellation shall be null and void. 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. I hereby state the statements are true and have been completed to the best of my knowledge and belief.

Signed at: City Patchogue State NY Date _____
mm/dd/yyyy

(x)_____
Signature of Proposed Insured (if applicable)

Agent Section

I hereby certify that: (a) all information set forth above is correct to the best of my knowledge and belief; (b) I have complied fully with the underwriting rules; (c) I have explained the proposed insurance coverage in detail.

Date _____ (x)_____
Signature of Licensed Agent (if applicable)

Agent Name_____ License No._____ Code No._____