DATA COLLECTION FORM
for Hospital Confinement Indemnity Coverage

Arranged by Special Insurance Services, Inc.

In order for Special Insurance Services to administer your employer-sponsored hospital confinement coverage and process any claims you might have accordingly, we will need the following information from you:

☐ NEW	☐ TERMINATION	☐ CHANGE

PLAN DATA

If your employer offered more than one hospital confinement plan design, which plan did you choose:

☐ Plan 1 - 2,000 ☐ Plan 2 - 5,000 ☐ ~~Plan 3~~ ☐ ~~Plan 4~~

Please indicate which coverage level you elected under your employer-sponsored hospital confinement coverage:

☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Employee & Family

EMPLOYEE INFORMATION

Last Name : _____ First Name: _____ M.I.: _____

Social Security #: _____ Gender: ☐ Female ☐ Male Date of Birth: _____ Age: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Email: _____

Employer: _____ Date of Hire: _____

Occupation/Job Title: _____ If retiree, Date of Retirement: _____

DEPENDENT INFORMATION (only those eligible may be enrolled)

A=Add T=Termination C=Change

A/T/C	Name (last, first, MI)	Relationship	Date of Birth	Gender	Social Security #
		☐ Spouse ☐ Child		☐ M ☐ F	
		☐ Spouse ☐ Child		☐ M ☐ F	
		☐ Spouse ☐ Child		☐ M ☐ F	
		☐ Spouse ☐ Child		☐ M ☐ F	
		☐ Spouse ☐ Child		☐ M ☐ F	
		☐ Spouse ☐ Child		☐ M ☐ F	
		☐ Spouse ☐ Child		☐ M ☐ F	

(Use reverse side of form is additional space is needed)

Requested Effective Date of Coverage/Change: _____

☐ I waived enrollment under my employer's sponsored hospital confinement plan at the time I was initially eligible to participate in the plan. I understand that I can only enroll in the plan during an employer-sponsored annual open enrollment period, or upon provision of satisfactory documentation evidencing my status as a special enrollee due to a qualifying event as determined by law.

Employee's Signature: _____ Date: _____