Payment Authorization: ES23069 - IBEW Railroad

☐ **I elect to pay my premium once per month** Payment date will be: _____ * Payment dates must be between the 1st and the 26th	LTD Premium:	
	Life and AD&D Premium:	
OR		
☐ **I elect to split my premium into two equal payments per month.** Payment dates will be: _____ & _____ * Payment dates must be between the 1st and the 26th	Processing Fee:	$1.00
	Total Monthly Premium:	

Please debit payments from my (check one):

☐ Checking Account

☐ Savings Account

Routing Number: _____

Routing # must start with 0, 1, 2, or 3

Account Number: _____

ROUTING NUMBER ACCOUNT NUMBER CHECK NUMBER

Enrollment Information

Enrollment must occur during an open enrollment period. If you are required to pay premiums for any coverage, the enrollment form must be signed and dated to authorize deductions from your bank account. The premium amounts indicated on this form are estimates and are subject to change based on the final terms and conditions of the policy as well as your salary and age on the effective date of the policy.

Agreement & Signature

I represent that the information I have provided in this enrollment form is complete, true, and accurate to the best of my knowledge. I understand that any fraudulent statements could lead to coverage being cancelled, denial of claim, and/or legal action. Should I apply for waived coverage in the future, I understand that evidence of insurability may be required, acceptable to the insurance company, at my own expense. I understand that if coverage is applied for in the future, it must be during an enrollment period or due to a life change event as defined by the policy, and that a waiting period may apply. I understand that payment of premium does not guarantee eligibility for coverage. I understand and agree that I must satisfy all eligibility requirements of the policy, including being an actively working IBEW Railroad member who is scheduled to work a minimum of 1,250 hours per year. I understand that if I fail to meet the minimum hours that it is my responsibility to contact Cornerstone. Failure to notify could result in a loss of premium. I understand that I must be actively at work, performing the duties of my occupation when the policy goes into effect.

I understand that this group plan has a minimum participation requirement of 15% that must be met for the plan to become effective. Failure to meet the participation requirement could prevent the plan from becoming effective or delay the effective date of the policy. Coverage will not be effective until approved by the insurance company or its designated underwriter. Submission of this form does not guarantee coverage. The effective date listed on this enrollment form or any other enrollment materials is subject to change. I understand and authorize Cornerstone to contact me regarding future open enrollments and renewals via text message or email. I also understand that rates and benefits may change at or before renewal and I authorize my ACH premium amounts to be adjusted accordingly.

By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summaries provided to me for each line of coverage. The above requirements will apply unless otherwise stated in the policy, or unless prohibited by any applicable state or federal law.

I authorize this organization to process debit entries to my account. I understand that this authority will remain in effect until I provide reasonable notification to terminate the authorization.

I understand that payment of premium does not ensure my eligibility for coverage.

Signature of Member: _____ **Date:** _____

Member Voluntary Benefits Enrollment Form - IBEW Railroad

For quick and easy enrollment, call 224-770-5312 (M-F 8:00am-5:00pm CST) to enroll over the phone

Please sign, date, and return this form to: **22333 Classic Court • Lake Barrington, IL 60010 Fax: 815-425-5349**
Please print clearly and mark carefully.

About You

Full Name: _____

Address: _____

Gender: ☐ Male ☐ Female Date of Birth: _____ SSN: _____

Mobile Phone: _____ Email: _____

Date of full time hire: _____ Annual Earnings: _____ *Earnings includes Salary & Overtime

Long-Term Disability Options

- Benefit pays after a 1 year waiting period
- Pre-existing conditions are covered after 12 months
- This benefit will be reduced once 70% of your pre-disability earnings are attained (offset)
- Includes $10,000 of Life/AD&D

☐ **I elect a monthly benefit of $2,000 for up to 2 Years**

☐ **I elect a monthly benefit of $2,000 for up to 5 Years**

Additional Life/AD&D Options

Member

- Guaranteed Amount: $200,000
- May be elected in increments of $10,000

☐ **I elect a benefit of**
$ _____

Spouse

- Guaranteed Amount: $50,000
- Cannot exceed 100% of Member Life

☐ **I elect a benefit of**
$ _____

Child(ren)/Dependent(s)

- All children covered at $10,000 for $3.16

☐ **I elect a benefit of**
$ 10,000

Your dependent children must be under 26 years old or disabled.

Life/AD&D Beneficiaries

Primary: _____ Date of Birth: _____ Relationship: _____ Percent: _____

Primary: _____ Date of Birth: _____ Relationship: _____ Percent: _____

Contingent: _____ Date of Birth: _____ Relationship: _____ Percent: _____

*Call 224-770-5312 if you need to list additional beneficiaries

Spouse Information

Name: _____ Date of Birth: _____ Mobile Phone: _____