

CFPB 24-Hour Accident Insurance Enrollment Form



A. Personal Information (to be completed by employee)

FIRST NAME	LAST NAME	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>

SOCIAL SECURITY NUMBER (No Dashes)	DATE OF BIRTH (MM/DD/YYYY)	GENDER
<input type="text"/>	<input type="text"/>	Male Female

STREET ADDRESS

CITY	STATE	ZIP CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>

WORK LOCATION (CITY/STATE)	CFPB DATE OF HIRE (MM/DD/YYYY)	GROUP CUSTOMER NUMBER
<input type="text"/>	<input type="text"/>	147398

REASON FOR ENROLLMENT/CHANGE (check all that apply)

New enrollment
 Add or delete dependents
 Qualifying event
 Open Season
 Decrease in coverage
 Cancel

SOLE EVENT TYPE (select one)

Marriage
 Divorce
 Death of child
 Birth/adoption of child
 Death of spouse
 Separation from domestic partner

B. Coverage Election (to be completed by employee)

Eligible employees may select from \$50,000 to \$250,000 of coverage in units of \$25,000, or amounts above \$250,000 may be selected in units of \$50,000 up to a maximum of \$500,000. Your benefit amount cannot exceed 10 times your base annual salary when the benefit amount selected is \$250,000 or more. You may select from an Employee Only Plan or Employee and Family Plan.

Employee and Family Coverage—Covers you at 100%. If this family benefit is elected and family includes a spouse/domestic partner and child(ren), the spouse/domestic partner benefit is 60% of the employee amount and the child(ren) benefit is 20% of the employee amount. If this family benefit is elected and the family includes employee and spouse/domestic partner only, the spouse/domestic partner benefit will be 70% of the employee amount. If this family benefit is elected and the family includes employee and child(ren) only, the child benefit would be 25% of the employee amount.

EMPLOYEE ONLY (check one below)

<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$175,000	<input type="checkbox"/> \$350,000
<input type="checkbox"/> \$75,000	<input type="checkbox"/> \$200,000	<input type="checkbox"/> \$400,000
<input type="checkbox"/> \$100,000	<input type="checkbox"/> \$225,000	<input type="checkbox"/> \$450,000
<input type="checkbox"/> \$125,000	<input type="checkbox"/> \$250,000	<input type="checkbox"/> \$500,000
<input type="checkbox"/> \$150,000	<input type="checkbox"/> \$300,000	

EMPLOYEE AND FAMILY (check one below)

<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$175,000	<input type="checkbox"/> \$350,000
<input type="checkbox"/> \$75,000	<input type="checkbox"/> \$200,000	<input type="checkbox"/> \$400,000
<input type="checkbox"/> \$100,000	<input type="checkbox"/> \$225,000	<input type="checkbox"/> \$450,000
<input type="checkbox"/> \$125,000	<input type="checkbox"/> \$250,000	<input type="checkbox"/> \$500,000
<input type="checkbox"/> \$150,000	<input type="checkbox"/> \$300,000	

B. Coverage Election (continued)

If electing Employee and Family please check whether you are electing coverage for a Spouse or Domestic Partner and print his/her name.

Spouse Domestic Partner

PRINT NAME OF SPOUSE OR DOMESTIC PARTNER

DATE (MM/DD/YYYY)

When enrolling a domestic partner, ensure that an Affidavit of Domestic Partnership for Benefits Coverage is on file with the Human Capital office.

C. Authorization

I authorize CFPB to withdraw premiums from my salary to pay the cost of the coverage that I have elected above.

SIGNATURE

DATE (MM/DD/YYYY)

For office use only

I certify that the above named employee is eligible for the insurance coverage he or she has elected above.

SIGNATURE OF REVIEWING HC REPRESENTATIVE

DATE RECEIVED (MM/DD/YYYY)

EFFECTIVE DATE (MM/DD/YYYY)

Coverage Amount	Employee Only	Employee and Family	Coverage Amount	Employee Only	Employee and Family	Plan code: CA (enter 2-digit coverage code)	<input type="text"/>
\$50,000	01	02	\$225,000	15	16		
\$75,000	03	04	\$250,000	17	18		
\$100,000	05	06	\$300,000	19	20		
\$125,000	07	08	\$350,000	21	22		
\$150,000	09	10	\$400,000	23	24		
\$175,000	11	12	\$450,000	25	26		
\$200,000	13	14	\$500,000	27	28		

Save the pdf application before submitting. (Submission will be sent via email.)

Fraud Warnings

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the insurance policy under which you are applying for coverage was issued.

Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Florida: A person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application 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.

Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

New York (only applies to Accident and Health Benefits (AD&D/Disability/Dental): 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Oklahoma: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon and Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Puerto Rico: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Pennsylvania and all other states: 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.