ISI INSURANCE TRUST

Comprehensive Accident Insurance Plan
Request for Coverage Form

Control #50006

Return this completed form to:
Insurance Specialists, Inc.
P.O. Box 2327
Beaufort, SC 29901
Phone: 800-241-7753 • Fax: 866-871-2170 • E-mail: sales@isi1959.com

Please print all answers using black ink.

1 Member Information

Association Name _____

First Name | MI | Last Name

Street | Apt.

City | State | ZIP code

Date of Birth (mm/dd/yyyy) | Social Security Number | Daytime Telephone Number

Sex ☐ Male ☐ Female | Height ☐ ft. ☐☐ in. | Weight ☐☐☐ lbs. | Evening Telephone Number

2 Spouse Information

Complete if you are requesting coverage for your spouse or domestic partner.

Please check ☐ Spouse

First Name | MI | Last Name

Date of Birth (mm/dd/yyyy) | Social Security Number | Daytime Telephone Number

Sex ☐ Male ☐ Female | Height ☐ ft. ☐☐ in. | Weight ☐☐☐ lbs. | Evening Telephone Number

3 Coverage Amounts

Choose the type of coverage and amounts for which you are applying.

☐ **Comprehensive Accident Insurance Plan**

Coverage Amounts *(please check one)*:

☐ **Option 1:** Provides up to $100,000 AD&D Principal sum coverage; $1,000 per month Accident Disability benefit for up to 12 months; $3,000 per month Accident Hospital Inpatient Benefit.

☐ **Option 2:** Provides up to $250,000 AD&D Principal sum coverage; $2,500 per month Accident Disability benefit for up to 24 months; $2,500 per month Accident Hospital Inpatient Benefit.

☐ **Option 3:** Provides up to $500,000 AD&D Principal sum coverage; $5,000 per month Accident Disability benefit for up to 24 months; $5,000 per month Accident Hospital Inpatient Benefit.

Coverage(s) Requested:
☐ Member only
☐ Member and Spouse Coverage

4 Beneficiary Information

If no beneficiary is designated below, the member will be the sole beneficiary of all AD&D coverage. Please consult your certificate of coverage for a more detailed explanation of beneficiary designation.

First Name	MI	Last Name	Address (include city, state, ZIP)	Relationship	Date of Birth	% Share
				Total (Must equal 100%)		**100%**

5 Contribution Payment Basis

I request the following payment basis *(please check one)*:

☐ Annual ☐ Semi-Annual ☐ Monthly Electronic Fund Transfer (EFT)*

** If electing EFT, you must complete the Electronic Fund Transfer Authorization section below*

6 Electronic Fund Transfer Authorization

If you wish to use your checking account, enclose a blank voided check for that account. If you wish to use your savings account, you must confirm that your bank permits electronic fund withdrawals from savings accounts. By my signature below I authorize the administrator in accordance with the Agreement (included on page 2 of this Form) to charge my bank account for the amount of my insurance contribution payment until such time as I provide written notice of cancellation, or insurance is terminated.

Type of Account:

☐ Checking ☐ Savings

Account Owner's Name

Bank Name

Bank's Transit Routing Number *(if savings account only)*

Your Savings Account Number

X

Signature of Account Owner

Date (mm/dd/yyyy)

X

Member Signature

Electronic Fund Transfer Authorization: **Insurance Specialists, Inc. Automatic Insurance Payment Program Agreement** provides for Electronic Fund Transfer for the purpose of making your insurance payment without the use of a check. Your signed authorization is required. The electronic debit will occur on the tenth of each month that the payment is due. If the transfer falls on a weekend or bank holiday, your checking/savings account will be charged the next business day. The amount of the automatic debit may vary due to changes in the amounts of insurance or a premium contribution charge. You will be notified in advance of changes to the amount of your debit due to premium contribution charges.

Please keep this notice for your records.