

Comprehensive Accident Plan

Summary of Coverage and Activation Form



Underwritten by: Hartford Life and Accident Insurance Company, Simsbury CT 06089

Who's Eligible?

All American College of Emergency Physicians members and/or Spouses under age 60 working 20+ hours/week and residents of the United States.

Benefit Limits:

The 50-50-500 Plan	The 100-100-1,000 Plan
\$50,000 Accidental Death	\$100,000 Accidental Death
\$50 per day Hospital Accident Plan	\$100 per day Hospital Accident Plan
\$500 Monthly Accident Disability	\$1,000 Monthly Accident Disability
Cost - \$8.95 per Month	Cost - \$17.00 per Month

Waiting Period:

Accident Only Disability Income-60 days
 Accident Hospital Confinement – 1st day of coverage

Maximum Benefit Period:

Accident Only Disability Income – 1 Year
 Accident Hospital Confinement – 500 days

Policy Age Limit: 65

Disability Income Benefit Offsets:

No coordination with other disability income plans (including any coordination with Worker's Compensation).

Exclusions:

- Loss caused or contributed by war or act of war, whether declared or not;
- Intentionally self-inflicted injury, suicide or attempted suicide, whether sane or insane;
- Injury sustained while in the armed forces of any country or international authority;
- Injury sustained while voluntarily taking drugs, unless prescribed for or administered by a licensed physician
- Injury sustained while legally intoxicated

Termination:

Non-payment of premium, cessation of work, or reach 65 years of age.

To activate coverage, please complete, detach and return the bottom portion to Hagan Benefits Inc.:

It's Easy to Activate Your Coverage!

1. Choose the appropriate benefit amount and waiting period.
2. Complete all sections below; be sure to sign where indicated.
3. Return the completed form to Hagan Benefits, Inc., the Administrator for ACEP.

Member Name: _____

Date of Birth: _____

Occupation: _____

Address: _____

Beneficiary: _____

I apply for the 50-50-500 Plan or 100-100-1,000 Plan

Is Spouse Coverage Desired? Yes No

(If yes, complete spouse information below.)

Spouse Name: _____

Date of Birth: _____

Occupation: _____

Beneficiary: _____

I apply for the 50-50-500 Plan or 100-100-1,000 Plan

Billing Mode Choices: *(No service charges apply no matter which billing mode you choose)*

Monthly Automatic Withdraw from Bank Account *(please provide "voided" check)*

Monthly Bill Quarterly Bill Semi-Annual Bill Annual Bill

Credit Card *(for annual premium only, please – please complete enclosed Authorization Form)*

I hereby request coverage under the Comprehensive Accident plan. I represent that I am under age 60, work at least 20 hours a week and that the statements above are true and complete to the best of my knowledge and belief and are binding on any person.

Member Signature: _____

Date: _____

Spouse Signature (if applicable): _____

Date: _____

Policy #ADD-11123