



### AUIC

Please enroll me as a member of the Association of United Internet Consumers (AUIC). I will receive a full association kit after receipt of my membership fee. AUIC provides members with many quality benefits and discounts. Your enrollment entitles you to medical air travel assist, accudiet.com, 24 hour emergency roadside assistance, auto, movie discounts, moving discounts, and much more. I understand that my membership fee is \$2 per month. Go to [www.AUIC.org](http://www.AUIC.org) for details.

Signature of Applicant

Date

## ENROLLMENT FORM FOR INSURANCE TO UNITED STATES FIRE INSURANCE COMPANY

Billing & Customer Service: SASid, 462 Midland Rd., Janesville WI 53546

### 1. Primary Insured's Information

Name (Last, First, MI) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security No. \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Street Address: \_\_\_\_\_ ND  
 (Street, City, State, Zip Code)

Billing Address: \_\_\_\_\_  
 (Street, City, State, Zip Code)

Email Address \_\_\_\_\_ Home Phone No. \_\_\_\_\_ Work Phone No. \_\_\_\_\_

a) **Occupation** (circle one): Construction Customer Service Healthcare Entertainment Logging Manufacturing  
 Mining Office/Clerical Truck/Taxi Driver Other: \_\_\_\_\_

b) **Are You An Independent Contractor?**  Yes  No

### 2. Dependent Information – Complete the following for each dependent to be insured:

Name (Last/First/Middle)	Relationship	Sex	Age	Date of Birth	Social Security No.
	Spouse				
	Child				
	Child				
	Child				
	Child				

### 3. Beneficiary Information – Complete the following for the Accidental Death & Dismemberment benefit:

Primary Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_

Contingent Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_

### 4. Plan Selected: Initial Premium\*: \$ Requested Effective Date:

\*If you are mailing this application in with payment you will need to include a one time \$10 enrollment fee. If you enroll online then you do not have to include the enrollment fee.

**APPLICANT'S STATEMENT**

By signing below, I and the individuals named herein are eligible for insurance and understand that coverage will not begin until the Effective Date shown in the coverage document. I further understand that the coverage applied for is supplemental coverage with limited benefits and is not intended to cover all medical expenses and that this coverage will not pay benefits during the Plan Period described below for any pre-existing conditions I/we currently have or have had in the past.

•Beginning on the Effective Date, benefits will not be paid for any pre-existing condition until the end of 12-consecutive months.

By signing below, I AUTHORIZE SASid, Inc. TO COLLECT ANY AND ALL PREMIUMS DUE FOR THIS COVERAGE.

Fraud Warning: Any person who knowingly and with intent, defrauds or deceives any insurance company by submitting an application or filing a claim that contains any false or incomplete information, or conceals information for the purpose of misleading, is guilty of insurance fraud, which is a felony and subject to criminal and/or civil penalties.

Signed in \_\_\_\_\_ (City, State) \_\_\_\_\_ Signature of Applicant \_\_\_\_\_ Date

EA-27330

**Payment Information**

I request that you honor account debits drawn from my account by SASid, Inc. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may at any time, end this agreement by giving 30 days advance written notice to me and to SASid, Inc. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable, even if it results in loss of my insurance.

**Credit Card Payment Request:**

I authorize SASid, Inc. To charge my credit card for Basic Health Insurance premium, fees and dues:

Visa \_\_\_\_\_ Account Number \_\_\_\_\_ Exp. Date \_\_\_\_\_ Sec. Code \_\_\_\_\_  
 Master Card \_\_\_\_\_  
 Discover Card \_\_\_\_\_ Prin Account Holders Name (as is on card) \_\_\_\_\_  
\_\_\_\_\_  
Signature of Card Holder \_\_\_\_\_ Date \_\_\_\_\_

**Automatic Check Withdrawal Request:** By selecting automatic check withdrawal, your Basic Health Insurance premium, fees, and dues will be withdrawn from your checking account until the term of insurance expires. Complete the form below. Attach a voided check and a check for the first months premium, fees, and dues.

\_\_\_\_\_  
Print Name of Bank or Institution \_\_\_\_\_ Address of Bank or Institution \_\_\_\_\_  
\_\_\_\_\_  
Bank Account Number \_\_\_\_\_ Bank Routing # \_\_\_\_\_  
\_\_\_\_\_  
Signature of Payer \_\_\_\_\_ Date \_\_\_\_\_

**For Agent Use Only**

\_\_\_\_\_  
Agents Full Name \_\_\_\_\_ Agent Number or SS# \_\_\_\_\_ Phone \_\_\_\_\_

Mail Applications to:  
SASid, Inc  
Attn: Core Health Plan  
PO Box 1086, Janesville, WI 53546  
1-800-279-2290 Fax (253) 595-6901