



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 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: _____ SD
(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

1. I agree that coverage will not become effective for any person whose medical history changes prior to coverage approval, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, coverage is automatically declined for all persons included in this application.
2. I hereby authorize any hospital, clinic, physician, surgeon, practitioner or insurance company to furnish the Insurer or its representative with any and all information concerning any sickness or injury I or my dependents may have suffered, including copies of all hospital or medical records. A copy of this authorization shall be considered as valid as the original and remains in effect for 2 years from the date of my signature.
3. I understand that the broker who solicited this application was acting as an independent contractor and not as an agent of United States Fire Insurance Company. I further acknowledge that the person who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied, was retained by me as my agent, and that such person has no right to bind or approve coverage or alter any of the terms or conditions of the policy.
4. I have read this application and have verified that all of the information provided in it is complete, true and correct, and is all within my personal knowledge. I agree to immediately notify the insurer of any changes in any of the information contained in this form which may occur prior to the approval of coverage.

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, maybe guilty of insurance fraud, which is a felony and maybe subject to criminal and/or civil penalties.

Signed in _____ (City, State) _____ Signature of Applicant _____ Date

EA27330-I

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