PROSPERITY LIFE GROUP®

S.USA LIFE INSURANCE COMPANY, INC.

Submit Completed Form to:
Administrative Office: 2679 S Main Street, STE #300715, Littleton, CO 80120
Phone: 833-708-4753

GROUP LIMITED BENEFIT FIXED INDEMNITY INSURANCE ENROLLMENT FORM

MEMBER INFORMATION

Last Name	First	M.I.	S.S. Number

Address	Birth Date	Male ☐ Female ☐

City	State	Zip

Email Address	Phone

PLEASE NOTE: In order to be eligible to apply for this coverage, you must be a member of the Alliance of Gig Workers, Inc. and under age 65.

Your lawful spouse, under age 65, and/or dependent children from birth to age 26 are eligible if you elect to cover them.

DEPENDENT INFORMATION

If you are applying for Dependent insurance, please complete the following information. *(If you need to add more Dependents, please use another sheet.)*

Dependent Full Name	Relationship	Birth Date	Sex
			Male ☐ Female ☐
			Male ☐ Female ☐
			Male ☐ Female ☐
			Male ☐ Female ☐

COVERAGE TYPE

☐ Individual ☐ Individual & Spouse ☐ Individual & Children ☐ Individual & Family

Please check your coverage of choice:	☐ Hospital Shield Silver ☐ Hospital Shield Gold

ACKNOWLEDGEMENTS

I/we hereby enroll for coverage issued by **S.USA Life Insurance Company, Inc.,** (herein referred to as "Company") and understand that if the coverage applied for becomes effective, I/we agree to all terms of the group Policy. I will receive a membership packet after my membership fees are received. If this Application is completed electronically, I/we agree that my/our electronic signature serves as my/our original signature. If this Application is not completed electronically, I/we agree to provide my/our verbal consent to certify my/our application in lieu of a signature.

I/we understand that:

- no insurance will be effective until the Company approves this Application, receives the required premium, and issues the Certificate of Insurance.
- I/we acknowledge I/we have received, read, and understand the disclosures.
- **This is a supplemental policy only and the benefits provided are limited**.

I/we 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/we understand that insurance benefits are excluded for Pre-Existing Conditions.

Signature of Applicant _____ Dated _____

If this Enrollment Form is taken by an agent, he/she hereby certifies that he/she has truly and accurately recorded on this Enrollment Form the information supplied by the applicant.

IMPORTANT NOTICE

THIS IS LIMITED BENEFIT INSURANCE: The Certificate provides limited benefits. Benefits provided are supplemental and are not intended to cover all medical expenses. Read your Certificate Carefully.

THIS IS A HOSPITAL FIXED INDEMNITY PLAN THAT IS NOT INTENDED TO QUALIFY AS THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA). UNLESS YOU PURCHASE A PLAN THAT PROVIDES MINIMUM ESSENTIAL COVERAGE IN ACCORDANCE WITH THE ACA, YOU MAY BE SUBJECT TO A FEDERAL TAX PENALTY. ALSO, THE TERMINATION OR LOSS OF THIS COVERAGE DOES NOT ENTITLE YOU TO A SPECIAL ENROLLMENT PERIOD TO PURCHASE A HEALTH BENEFIT PLAN THAT QUALIFIES AS MINIMUM ESSENTIAL COVERAGE OUTSIDE OF AN OPEN ENROLLMENT PERIOD.

Please check the appropriate box:

☐ I am already a member of the Alliance of Gig Workers, Inc.

☐ I am not a member of the Alliance of Gig Workers, Inc. I hereby request to be enrolled as a member. I will receive a membership packet after my membership fees of $xx are received.

Underwritten by: S.USA Life Insurance Company, Inc.

FRAUD NOTICE: 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 may be guilty of a criminal offense and subject to penalties under state law.