



North East Independent School District

HOSPITAL INDEMNITY PLAN

\$10,000 Change of Beneficiary

INSTRUCTIONS: Please print all information.

Employee's Name (Last, First, Middle)				Employee Identification No.		Campus/Department		
Address (Number, Street, Apartment)			City	State	Zip Code	Home Phone No.		Work Phone No.
Date of Birth Mo/Day/Yr / /	Sex __M __F	Marital Status __ Single __ Divorced __ Married __ Widowed		Children __ Yes __ No	Occupation		Date Employed / /	# Hrs. Per Week _ Monthly _ Bi-Weekly
<i>Primary Beneficiary</i>					<i>Secondary Beneficiary</i>			
Name					Name			
Address					Address			
Relationship			Date of Birth		Relationship			Date of Birth

PLEASE READ THE FOLLOWING CAREFULLY:

1. I am currently performing the duties of my regular occupation on a regularly scheduled work week of not less than the minimum required for eligibility under the Group Policy.
2. I understand that any misstatement on this enrollment application may result in a denial of a claim and/or discontinuance of coverage.

Signature

Date

Hospital Indemnity Benefit is a plan that provides a daily hospital benefit toward room and board expenses for employees who do not participate in any medical program through the District. In addition, participants are covered by a \$10,000 group term life insurance policy.