Employer Group Critical Illness Insurance Consent Form

This form is to be completed by employees who wish to enroll in the Employer Group Critical Illness Insurance plan. Please read the following consent information carefully before signing.

Employee Information

Name: _____
Employee ID: _____
Department: _____
Date of Birth: _____

Consent & Authorization

By signing below, I hereby consent to participate in the Employer Group Critical Illness Insurance plan. I acknowledge that I have received and reviewed the summary of benefits and exclusions for this coverage.

I authorize my employer to enroll me in the Group Critical Illness Insurance plan and to make any applicable payroll deductions for the premiums associated with this coverage.

I understand that coverage is subject to the terms, conditions, and provisions of the insurance policy as issued by the provider.

_____
Signature of Employee

_____
Date