

Enrollment Is Easy ...

You can give your family the extra protection of the New SHIP Hospital Indemnity Plan in minutes...

1. Complete this Enrollment Form.
2. Make sure you elect the coverage option you want.
3. Calculate your rates based on how you want to make your payments (See Chart or call).
4. Mail your completed Enrollment Form with your first premium payment to:

SHIP ADMINISTRATOR
 7212 Poplar Street • P.O. Box 828
 Annandale, VA 22003-0828
 1-800-221-3083

Check our Website for all the supplemental programs especially designed for Federal employees

www.massbenefits.com

Payment Options:

- Bi-Weekly Direct Deposit (The Direct Deposit form is available on our website: www.massbenefits.com or call the SHIP Plan Administrator 1-800-221-3083.)
- Monthly Check Service (Call the SHIP Administrator for the monthly cost. Complete the form to the right.)
- Quarterly Direct Bill
- Semi-Annual Direct Bill
- Annual Direct Bill

(Call the SHIP Administrator for monthly, quarterly, semi-annual and annual cost. Mail the payment with the completed application.)

Make check payable to:

GEVBT Plan Administrator

Amount Enclosed \$ _____ Date _____

NOTE: This information is a brief description of Important features of the SHIP Hospital Indemnity Plan It is not a contract. Terms and conditions of coverage are set forth in group policy number G-29162-0, on policy form GMR issued to the Government Employees Voluntary Benefit Trust (GEVBT).

Request for Preauthorized Check

GEVBT Plan Administrator is hereby requested and authorized to present checks drawn on my checking account number _____ beginning on or about the 10th day of _____ 20 _____ and on or about the same day of each month thereafter until this authorization is revoked. I understand that all advance premiums will be refunded to me if my policy is not issued and that the effective date of my insurance will be the date stated in my policy.

(Note: Your signature below the bank authorization portion will also apply to the above authorization.)

IMPORTANT: Be sure to include a voided blank check for your bank checking account with this authorization.

Print the name and address of your bank.

Bank _____

Address _____

City _____ State _____ Zip _____

Authorization to Honor Checks Drawn in the Name of GEVBT Plan Administrator

As a convenience to me, the undersigned, I hereby request and authorize you to pay and charge to my account checks drawn on my account in the name of GEVBT Plan Administrator. This authorization will remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such check.

I agree that your treatment of each such check and your rights with respect to it shall be the same as if it were signed personally by me. I further agree that if any such check is dishonored, whether with or without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

GEVBT Plan Administrator is instructed to forward this authorization to you.

 DATE SIGNATURE OF BANK DEPOSITOR – AS SHOWN ON BANK RECORDS ACCOUNT TO WHICH THIS AUTHORIZATION IS APPLICABLE

 CHECKING ACCOUNT NUMBER

 PRINTED NAME OF BANK DEPOSITOR

 NAME OF BANK AND BRANCH NAME IF ANY TRANSIT NO. 776-02

Your Personal Guarantee of Satisfaction

After your Enrollment Form has been accepted, you will receive a Certificate of Insurance describing the Plan's benefits in detail. If you decide, for any reason, that you do not want to continue coverage, return the Certificate within 30 days. You'll get a full refund, with no questions or obligations.

Plan Exclusions & Limitations

Benefits provided only for confinements, which begin while insured for which a room and board charge is made, and which are recommended by a doctor as medically necessary to treat a sickness or accident. Benefits are not provided for confinements caused by, resulting from or contributed to by: intentionally self-inflicted injury, while sane or insane (Missouri while sane); treatment of a nervous or mental condition, alcoholism or drug addiction; injuries resulting from active military service; dental care, except as a result of injury to sound natural teeth; well-baby care of a newborn dependent child; treatment or service rendered in any Hospital or Convalescent Facility owned or operated by the Government where, in the absence of insurance, there is no legal obligation to pay (Exclusions may differ in your state. See your Certificate of Insurance for details); declared or undeclared war or any act of war; pregnancy (except Complication of Pregnancy, as defined in your certificate of insurance); expenses incurred or care received outside of the United States; participating in a crime, illegal activity; or a pre-existing condition as defined below.

When coverage becomes effective:

Insurance on you and your eligible dependents will take effect on the first of the month following the date your enrollment form is received and approved by New York Life, provided the initial premium deposit for insurance is paid for monthly Check Service or Quarterly Direct Bill, or the first day of the pay period following the date the first deduction is received for Bi-Weekly Direct Deposit. You and any person to be insured must be performing the normal activities of a person in good health of like age and sex on the later of the date of approval and the premium is paid.

Additional dependents may be automatically covered

Generally you must apply for coverage for new dependents. But there is an important exception: If you have any dependent hospital indemnity insurance in force, newborn children are automatically covered from birth for 31 days. This coverage will be continued if there is medical insurance in force on other dependent children. You must inform the SHIP administrator in writing of the child's name and date of birth. If there is no dependent coverage in force and if you want to continue this automatic coverage, you must notify the SHIP Administrator within 31 days and remit the extra premium needed.

When Coverage Ends

You may continue your coverage as long as you: remain a member; pay your premiums when due; don't enter in the armed forces for more than 30 days of active duty; are under age 70; or, the Master Policy is not terminated or modified to end your coverage. Dependent coverage ends when they are no longer eligible or when your coverage ends.

Definition: Pre-Existing Condition

Conditions for which an individual consulted a doctor or received any medical services or supplies, or took any medication, during the 12 months prior to their effective date of coverage won't be covered until after: 12 consecutive months have elapsed while insured and during which no treatment, care or advice was received for that condition; or, after 24 consecutive months of coverage under the plan.

Definition: Hospital

A "hospital" is a licensed institution primarily engaged in providing in-patient medical services. It must have permanent facilities for diagnosis and surgery, 24-hour nursing by registered nurses and continuous supervision by one or more doctors. It does not include a convalescent home, nursing home, rest home, an extended care facility or place for the aged.

Your Plan Administrator

Mass Benefits Consultants (MBC), administrator of the SHIP Plan, has been designing innovative insurance programs for Federal employees for over 30 years. MBC has a reputation for providing personal service and has designed quality programs for hundreds of thousands of Federal Employees.

Coverage From A Company You Can Trust

It is important more than ever to get your family's insurance from a company with a reputation for financial strength. SHIP is underwritten by New York Life Insurance Company, New York, NY 10010. New York Life has consistently received among the highest ratings from the leading independent rating services; A.M. Best, Standard & Poor's and Moody's and Fitch Ratings for its financial strength.