U-Select® Program
ENROLLMENT

Payroll Deduction Authorization/ Waiver

Employee Name: ______________________________ Employee ID#: ______________

Employer Name: ______________________________ (referred to below as "you")

All applications are subject to underwriting approval.

1

Date of first deduction: ______________

Pay period mode:

- ☐ Weekly
- ☐ Bi-weekly
- ☐ Twice monthly
- ☐ Monthly
- ☐ 10thly
- ☐ 9thly

BENEFIT TYPE	DEDUCTION AMOUNT
Level Term Protector	$__________
Universal Life Protector	$__________
Disability Income Protector	$__________
Crit. Condition/Crit. Care Protector Plus	$__________
Cancer Care Protector	$__________
Accident Protector/Protector Plus	$__________
Catastrophic Accident Protector (AD&D)	$__________
Personal Accident Protector	$__________
Accident & Sickness Protector (ASHIP)	$__________
Champion: Accident	$__________
Champion: Critical Illness	$__________
Champion: LifeTime Benefit Term	$__________
High Deductible Buffer	$__________
Other: ______________	$__________

$ ________ New Deduction *(per pay period)* + **$ ________ Total Existing Deduction** *(per pay period)* = **$ ________ Total Deduction** *(per pay period)*

☐ I have made application for insurance and authorize you to deduct from my wages or account the amount required to pay the premium due and transmit it to Combined Insurance Company of America.

I also authorize you to change the amount of my deduction: (1) to correct clerical errors in the initial premium calculation for the above selected coverage(s) and (2) to reflect changes in premium resulting from Combined Insurance's underwriting actions, any changes in coverage I may request, and any automatic premium increase that may be required under the terms of my policy(ies). These changes in the amount of my deduction are to be made only at the direction of Combined Insurance and such change(s) does not require any other subsequent or additional authorization by me.

This authorization shall be effective until the earliest of (1) completion of the premium paying period provided in the policy, (2) written notice by me to cancel this authorization stating when such cancellation shall be effective, or (3) until termination of this premium payment method by Combined Insurance.

2

☐ I have been informed about my employer provided benefits and how to obtain information about my Social Security benefits, but will not participate in the *U-Select* program.

3

☐ I do not wish to meet with a Benefit Insurance Specialist to hear about my employer provided benefits nor do I want to participate in the *U-Select* program.

4

☐ I am currently participating in the *U-Select* benefits program and do not wish to make any additions or changes at this time.

Employee Signature: ______________________________ Date: ______________

This Authorization/Waiver form is also available in Spanish. • Esta forma de Autorización/Renuncia está disponible in Español también.

The *U-Select* program is provided by Combined Insurance Company of America, Worksite Solutions division.

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WHITE (*U-Select* copy) **YELLOW (to be retained by employer)** **PINK (Employee copy)**