

CareerGuard[®] Professional Liability Insurance ENROLLMENT FORM

First Name: _____ Middle Initial: _____

Last Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Work Phone: (____) _____ E-Mail: _____

Agency: _____ Social Security #: _____

Payment Method (check one): Annual; Semi-Annual; Quarterly;
 Monthly (Automatic Debit); Bi-Weekly Payroll Deduction **

** If you choose Bi-Weekly Payroll Deduction, you must start your allotment through Employee Express, My Pay, or Employee Personal Page (EPP) AND mail or fax this form to Mass Benefits (fax # 703-642-2240). All other applications should include the first premium payment with the application.

<u>Coverage</u> (Circle A, B, C, D)	<u>Annual</u> <u>Payments</u>	<u>Semi-annual</u> <u>Payments</u>	<u>Quarterly</u> <u>Payments</u>	<u>Monthly</u> <u>Payments</u>	<u>Bi-Weekly</u> <u>Payments</u>
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\$1,000,000 Civil Claims Limit:

Option A (\$100,000)	\$266.00	\$133.00	\$66.50	\$22.17	\$11.00
Option B (\$200,000)	\$305.00	\$152.50	\$76.25	\$25.42	\$12.00

\$2,000,000 Civil Claims Limit:

Option C (\$100,000)	\$332.00	\$166.00	\$83.00	\$27.67	\$13.00
Option D (\$200,000)	\$381.00	\$190.50	\$95.25	\$31.75	\$15.00

I hereby apply for coverage under the CareerGuard[®] policy for which I am eligible as an employee of the Federal Government in good standing. I also attest that, as of this date, I have no knowledge of any allegation, claim or suit, or any act, error or omission which might reasonably be expected to result in a claim or suit.

Signature: _____ Date: _____

**To enroll, complete this application and mail with payment to:
 Mass Benefits Consultants, Inc., P.O. Box 828, Annandale, VA 22003-0828**