

**Note:** If you have signed up previously, you can discard this application. If not, you must complete this form and mail it back by November 30, 2004 for the NO COST protection and/or additional coverage.

**ENROLLMENT APPLICATION**

**YES**, please enroll me in the Professional Law Enforcement Association Accident Program.

**Annual Premium\***

**Limits**       **Member (Individual)**       **Family Plan (Member, Spouse, Children)**

50,000	<input type="checkbox"/> 25.00	<input type="checkbox"/> 31.00	Dependent children are defined as those under age 19, but children age 19 and under age 23 are eligible if they are full-time students in an accredited school, college or university and primarily dependent upon the member for support and maintenance.
100,000	<input type="checkbox"/> 49.00	<input type="checkbox"/> 61.00	
150,000	<input type="checkbox"/> 73.00	<input type="checkbox"/> 91.00	
200,000	<input type="checkbox"/> 97.00	<input type="checkbox"/> 121.00	
250,000	<input type="checkbox"/> 121.00	<input type="checkbox"/> 151.00	
300,000	<input type="checkbox"/> 145.00	<input type="checkbox"/> 181.00	

**WAIVER OF ADDITIONAL INSURANCE.** I DO NOT want Additional Coverage for myself or my family under this Group Plan. I am providing the necessary information for the "no-cost" coverage only.

SOC. SEC.# (Last 4 Digits Only): \_\_\_\_\_ PHONE# (    ) \_\_\_\_\_

(Please Print)  
MEMBER NAME \_\_\_\_\_ AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

LODGE NAME AND NUMBER \_\_\_\_\_

BENEFICIARY \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

After approval, your increased coverage will take effect on the first of the month following receipt of your premium and signed application. No coverage will be put in force until completed form is on file.

As an FOP member in good standing, I hereby apply for enrollment in the PLEA Accidental Death and Dismemberment Plan and participation in the PLEA trust. I agree to abide by all the terms and conditions thereof. After my application is approved, I understand that my coverage will be effective the first day of the month following receipt of my check and completed enrollment form.

DATE \_\_\_\_\_ SIGNATURE \_\_\_\_\_

**Make Check Payable to: "Republic Underwriters, Inc." and Mail this Enrollment Form and Check to: Michigan State Lodge FOP.** For further information, call Toll Free 1-800-367-4321, ext. 1010.

\* Includes \$1.00 Administration Fee.

**Check Enclosed** (you will receive an invoice annually from Republic Underwriters, Inc.).

Please put my premium payment on my Visa or MasterCard.



Please re-bill my credit card annually.

Please charge my credit card for this year only and bill me next year.

<p align="center"><u>For Visa / MasterCard</u> → All Fields must be filled out completely.</p>	Name: _____
	Card Number: _____
	Expiration Date: _____
	Signature: _____