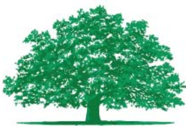


CANOPY INSURANCE
ROOTED IN ALABAMA

Send Completed forms: AWM, P O Box 380968, Birmingham AL 35238
fax - 866.266.9774 email - support@awm.cc

Group Benefit Plan

Enrollment / Change Form

Check one: ☐ New Employee ☐ Open Enrollment ☐ Add/Delete Dependent ☐ Terminate Coverage
☐ Other ____________________

EMPLOYER GROUP INFORMATION
(to be completed by the Policyholder or Group Administrator)

Employer Group Name:		
Group Number:		Requested Effective Date:
Hours Worked per Week	Actively at Work: ☐ Yes ☐ No	Hire Date:

EMPLOYEE INFORMATION
(to be completed by the Employee)

Employee Name: *(First) (Middle) (Last)*		
Address: *(Street) (City) (State) (Zip)*		
Social Security Number:	Work Telephone:	
Email:	Home Telephone:	
Marital Status:	Gender: ☐ Male ☐ Female	Date of Birth: *(MM/DD/YY)*

PLAN AND COVERAGE

Coverage(s) Requested	Dental	Vision	CI	Accident
Plan Type:	☐	☐	☐	☐ Gold ☐ Gold w/ Hospital Sickness Rider
CI Coverage Amount			$	
Other Coverage (Y/N)				

If Yes, list other Carrier's Name(s):

Enrollment Instructions

1.Select the plan(s) for which you are enrolling in and check the box above.

2. Fill in Dependent information, being sure to include the names of all dependents you wish to include on your plan.

3. Sign the Authorization for Deduction section at the bottom.

Dental
☐ Employee $________
☐ Employee + 1 $________
☐ Family $________

Vision
☐ Employee $________
☐ Employee + 1 $________
☐ Family $________

Critical Illness
☐ Employee $________
☐ Family $________

Accident
☐ Employee $________
☐ Employee + Spouse $________
☐ Employee + Children $________
☐ Family $________

CRITICAL ILLNESS ONLY

	Employee		Spouse	
	Yes	No	Yes	No
1. Have you or your spouse used tobacco products within in the last 12 months?	☐	☐	☐	☐

DEPENDENT INFORMATION

(please attach additional pages as needed)

	Name *(First)* *(Middle)* *(Last)*	Soc. Sec. No.	Male	Female	Date of Birth *(MM/DD/YY)*	Add	Delete
Spouse			☐	☐		☐	☐
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐

BENEFICIARY INFORMATION (for accident/critical illness only)

Primary Beneficiary Name *(First)* *(Middle)* *(Last)*	Relationship	Soc. Sec. No.	Date of Birth *(MM/DD/YY)*	Share %

Contingent Beneficiary Name *(First)* *(Middle)* *(Last)*	Relationship	Soc. Sec. No.	Date of Birth *(MM/DD/YY)*	Share %

AUTHORIZATION

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines or confinement in prison, or any combination thereof.

I elect the coverage selected for which I am eligible and understand that a monthly administration fee of $5.00 will be included in the monthly bank draft.

Signature:_______________________________________ **Date**:_______________________________

REFUSAL/WAIVER

(Complete ONLY if you are declining coverage)

I decline coverage.

Signature:_______________________________________ **Date**:_______________________________

Banking Authorization Form

Company/Participant Name: ____

Contact Name and Title: ____

Email: ________________________________ **Effective Date:** __________________________________

FEIN/SSN: _____________________________ **Financial Institution Name:** ________________________

Account Type: **CHECKING** __________ **SAVINGS** __________

Routing Transit Number (all nine boxes must be filled)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Account Number (do not include hyphens, spaces, or special symbols)

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

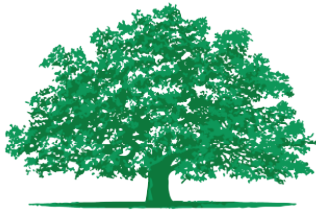
By signing this agreement, I authorize AWM to initiate credit and/or debit entries to the Account(s) indicated above for the purpose of reimbursements or remittances and to initiate, if necessary, adjustments for any entries made in error.

Signature:____Date:_________________________

**********************SIGNATURE CARD*********************

Please return this form either by email to billing@awm.cc or by fax to 866-226-9774.

Anderson Williams McKinnis & Co. Inc
P O Box 380968
Birmingham AL 35238
www.awm125.com
800.723.8908



AWM Benefit Plan

Summary of Dental Benefits – CIC0070030

Benefit Plan Year: July 1 – June 30

Rate Hold Guarantee: Jul 1, 2023 – Jun 30, 2024

Monthly Rates: **Member:** $ 27.46 **Member + 1 Dependent:** $ 68.03 **Member + Family:** $ 89.61

	Participating Dentist PPO MAC Schedule	**Non-Participating Dentist** PPO MAC Schedule
Class A – Preventative & Diagnostic	100% of maximum allowable charge	100% of maximum allowable charge
Class B – Basic Services	80% of maximum allowable charge	80% of maximum allowable charge
Class C – Major Services	50% of maximum allowable charge	50% of maximum allowable charge
Class D – Orthodontic Services (up to age 19)	50% of maximum allowable charge	50% of maximum allowable charge
Benefit Waiting Period – Class B, C, & D	6 Months	6 Months
Individual Deductible per Plan Year Class A, B, and C	$50 Applies to Class B & C	$50 Applies to Class B & C
Family Deductible Maximum per Plan Year Class A, B, and C	$150 Maximum of 3 per family	$150 Maximum of 3 per family
Plan Year Maximum Benefit - Class A, B, and C	$1,000	$1,000

Additional Coverage		
Evidence Based Benefits – pregnancy, diabetes, heart disease	1 additional exam and cleaning per plan year – Physician statement required	
Oral Cancer Screening (age 40+)	1 per 24 months	Up to $40
Individual Annual Orthodontic Deductible	$50	
Benefit Waiting Period – Class D	6 Months	
Plan Year Maximum Benefit – Class D	$500	
Lifetime Orthodontic Maximum Benefit	$1,000	

Class A Dental Services		**Class B Dental Services**	**Class C Dental Services**	
Prophylaxis	Diagnostic Casts	Palliative Care	Endodontics	Inlays
Oral Exams	Anesthesia	Prosthodontic Repairs	Periodontics	Onlays
Fluoride TX - Child	Sealants	Fillings	Crowns	Dentures
X-Rays – BW & FMX		Simple Extractions	Bridges	Partials
Space Maintainers		Surgical Extractions	Complex Oral Surgery (Not covered by medical)	

Participating DentaNet Dentists **-** This Plan contains a Participating Dentist arrangement. Covered Dental Services are based on the Maximum Allowable Charge Schedule. If a Covered Person uses the services of a participating DentaNet Dentist, that dentist is entitled to collect from you the difference between the amount of benefits payable by Company and the Maximum Allowable Charge. If a Covered Person uses the services of a Non-Participating Dentist, that dentist is entitled to collect from you the difference between the amount of benefits payable by Company and the dentist's usual and customary charge.

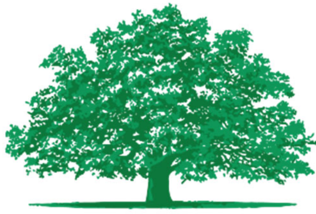
Benefit Adjustments **-** Benefits will be coordinated with any other dental coverage. Under the Alternative Dental Treatment provision, benefits will be payable for the most economical procedure meeting broadly accepted standards of dental care. It is recommended that all treatment plans exceeding $300 be submitted for an estimate of benefits payable.

Limitations and Exclusions **-** Benefits aren't payable for care not listed under the Schedule of Dental Services in the group policy, care that is not necessary, care not professionally endorsed, or care that is experimental or cosmetic in nature. For a complete list of limitations and exclusions, please refer to the group policy documents.

Open Enrollment **–** There shall be an Open Enrollment Period each year during which the Membership Organization is given no less than thirty (30) days to offer eligible Subscribers an opportunity to elect coverage or make changes to their existing coverage. Open Enrollment is typically the thirty (30) days prior to the policy anniversary date, i.e. policy anniversary date is January 1, open enrollment is held during the month of December. The Open Enrollment Period can be changed to correspond with any Medical or Cafeteria Plan enrollments.

Please call us at 205-451-0444 if you have questions regarding your coverage, claims or need assistance locating a provider.

This summary is a brief description of the plan benefits and is designed to highlight features of the program only. A more complete description of benefits and exclusions is found in the Certificate of Coverage.



AWM Benefit Plan

Summary of Vision Benefits – CIC0070030
Benefit Plan Year: July 1 – June 30
Benefit Frequency: Rolling Based on Date of Service
Rate Hold Guarantee: Jul 1, 2023 – Jun 30, 2025

Co-Pays[1]	
Eye Examination	$ 10
Materials[2]	$ 25
Contact Lens Fitting	$ 25

Services	Frequency (Months)
Eye Examination	12
Frames	24
Contact Lens Fitting	12
Lenses	12
Contact Lenses	12

Tier	Monthly Premium
Member Only	$ 8.13
Member + 1 Dependent	$ 15.76
Member + Family	$ 23.18

Benefits[3,4]	In-Network	Out-of-Network
Eye Examination (Ophthalmologist)	Covered in Full	Up to $ 35
Eye Examination (Optometrist)	Covered in Full	Up to $ 25
Frame Allowance	$ 130 Retail Allowance	Up to $ 75
Contact Lens Fitting (Standard)[5]	Covered in Full	N/A
Contact Lens Fitting (Specialty)[6]	Covered in Full	N/A
Lenses (Standard) Per Pair:		
Single Vision Lenses	Covered in Full	Up to $ 25
Lined Bifocals	Covered in Full	Up to $ 40
Lined Trifocals	Covered in Full	Up to $ 50
Standard Progressive[7]	Covered at Price of Lined Trifocals	Up to $ 40
Lenticular	Covered in Full	Up to $ 80
Polycarbonate for Dependent Children	Covered in Full	N/A
Contact Lens Allowance: Elective	$ 130 Retail Allowance	Up to $ 100
Contact Lens Allowance: Medically Necessary	Covered In Full	Up to $ 200

VisaNet Participating VisaNet Providers – This Plan contains a Participating Provider arrangement. Insureds have the right to obtain vision care from the Provider of their choice. Covered charges will be reimbursed according to the Schedule in the Certificate of Coverage.

Limitations and Exclusions - Benefits are not payable for care not listed in the Schedule of Services in the group Certificate. For a complete list of all limitations and exclusions, please refer to the group Policy documents.

Open Enrollment – There shall be an Open Enrollment Period each year during which the Group is given no less than thirty (30) days to offer eligible Applicants an opportunity to elect coverage or make changes to their existing coverage. Open Enrollment is typically the thirty (30) days prior to the Policy Anniversary Date, i.e., Policy Anniversary date is January 1, open enrollment is held during the month of December. The Open Enrollment Period can be changed to correspond with any Medical or Cafeteria Plan enrollments.

Please call us at 205-451-0444 if you have questions regarding your coverage, claims or need assistance locating a provider.

This summary is a brief description of the plan benefits and is designed to highlight features of the program only. A more complete description of benefits and exclusions is found in the Certificate of Coverage.

[1] Co-pays apply to in-network benefits; co-pays for out-of-network benefits are deducted from reimbursements.
[2] Materials Co-Pay applies to lenses or frames only, no contact lenses.
[3] All allowances are at a retail value; the insured is responsible for any charges exceeding this retail allowance.
[4] Contact lenses are in lieu of eyeglass lenses and frames benefit.
[5] Standard Contact Lens Fitting applies to a current contact lens user who wears disposable, daily wear, or extended wear lenses only.
[6] Specialty Contact Lens Fitting applies to new contact wearers and/or a member who wears toric, gas permeable, or multi-focal lenses.

CANOPY INSURANCE
ROOTED IN ALABAMA

Accident Insurance

Don't let an accident hurt your bank account too

Benefits that pay for covered accidents while you are on the road to recovery

Canopy's coverage provides a lump-sum benefit based on the type of injury (or covered incident) you sustain or the type of treatment you need.

Examples of covered injuries include:
- **Broken bones**
- **Burns**
- **Torn ligaments**
- **Concussions**
- **Eye injuries**
- **Ruptured discs**
- **Lacerations**

Some covered expenses include:
- **Emergency room treatment**
- **Doctor's office visit**
- **Hospitalization**
- **Physical therapy**
- **Imaging (X-ray, MRI, CT scan)**

See schedule of benefits for full list of covered injuries and expenses.

Who's at risk?

- 55.4 million non-fatal preventable accidents occurred in 2020, more than 150,000 per day.
- More than three times as many injuries requiring medical attention happen off the job rather than at work. [1]

[1]NationalSafetyCouncil

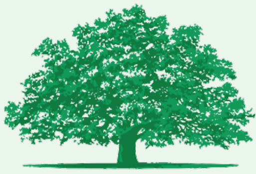
An illustrative example of how accident coverage can help you with your expenses*

45-year-old claimant
Accident: Fall at home
Injury: Broken forearm and laceration requiring 4 stitches

Out-of-pocket expenses incurred:
$100 emergency room co-pay
$2,500 deductible for diagnosis and treatment
$150 co-pay for 4 physical therapy visits
Total out-of-pocket expenses: $2,750

Benefits paid:
$200 emergency room visit
$50 for X-rays
$1,500 fractured forearm
$250 for stitches
$200 for 2 follow-up appointments
$120 for four physical therapy sessions
Total benefit paid under policy: $2,320

**Costs of treatment and your plan's benefit payout may vary from this example. Please see your plan's benefit schedule for actual amounts.*



Anderson Williams Mckinnis & Co Inc

Summary of Accident Benefits - SBS0005084

Benefit Plan Year:

July 1, 2023 - June 30, 2024

Canopy Accident Policy

Monthly Rates

Employee Only	**$22.52**
Employee + Spouse	**$38.64**
Employee + Children	**$48.16**
Family	**$67.26**

Initial Care and Treatment

Ambulance - Ground	**$500**
Ambulance - Air	**$1,500**
Doctor's Office Visit	**$50**
Urgent Care Facility Visit	**$50**
Emergency Room Visit	**$200**
Therapy - Occupational, Physical,Speech Per Visit [10 Visits Max]	**$30**
X-Rays	**$50**
Emergency Room Observation	**$200**
Major Diagnostic Testing	**$150**
Blood, Plasma, and Platelets Transfusion	**$300**

Inpatient Hospital Care

Hospital Admission	**$1,000**
Hospital Confinement per day	**$250**
Intensive Care Unit Confinement per day	**$500**

Followup Care & Treatment

Prosthesis - One	**$500**
Prosthesis - Multiple	**$1,000**
Pain Management - Epidural	**$150**
Accident Follow-Up Treatment Per Visit - 2 Visits Max	**$50**
Chiropractic or Althernative Therapy Per Visit - 5 Visits Max	**$30**

Lacerations

Lacerations - No Stitches	**$100**
Lacerations - With stitches, less than 2 inches	**$250**
Lacerations - With stitches, 2 to 6 inches	**$500**
Lacerations - With stitches, more than 6 inches	**$750**

Injuries

Concussion	**$150**
Coma	**$10,000**
Emergency Dental Work - Broken Teeth Extraction	**$100**
Emergency Dental Work - Broken Teeth Repaired with Crown	**$300**
Eye Injuries	**$300**

Burns

Burn - 2nd degree covering at least 36% of body	**$1,000**
Burn - 3rd degree covering 9 to 35 sq in. of body	**$3,000**
Burn - 3rd degree covering over 35 sq in. of body	**$12,000**
Skin Grafts - % of Benefit Amount	**25%**

Dislocations

	Non-Surgical Repair	Surgical Repair
Hip Joint	**$3,000**	**$6,000**
Knee Joint (excluding Patella)	**$1,500**	**$3,000**
Ankle Joint or Bone or Bones or the Foot Other than Toes	**$1,200**	**$2,400**
Lower Jaw	**$450**	**$900**
Wrist Joint	**$450**	**$900**
Elbow Joint	**$450**	**$900**
Shoulder Joint	**$450**	**$900**
Bone or Bones or the Hand Other than Fingers	**$450**	**$900**
Collarbone (Sternoclavicular)	**$750**	**$1,500**
Collarbone (Acromioclavicular and Separation)	**$150**	**$300**
One Finger or One Toe	**$150**	**$300**

Fractures

	Non-Surgical Repair	Surgical Repair
Skull - Depressed (excluding bones of face or nose)	**$3,750**	**$7,500**
Skull - Simple non-depressed (linear)	**$1,500**	**$3,000**
Hip, Thigh (femur)	**$2,250**	**$4,500**
Pelvis (excluding Coccyx)	**$1,125**	**$2,250**
Arm, Between Shoulder and Elbow (Shaft)	**$1,125**	**$2,250**
Leg (Tibia or Fibula)	**$1,125**	**$2,250**
Vertebrae, Body of (except Vertebral processes)	**$1,125**	**$2,250**
Vertebral Processes	**$450**	**$900**
Ankle	**$450**	**$900**
Knee Cap (Patella)	**$450**	**$900**
Finger, Toe	**$150**	**$300**
Foot (Except Toes)	**$450**	**$900**
Forearm, Hand, or Wrist (except fingers)	**$450**	**$900**
Lower Jaw (Except Alveolar Process)	**$450**	**$900**
Upper Jaw (Except Alveolar Process)	**$525**	**$1,050**
Bones of Face or Nose	**$525**	**$1,050**
Rib	**$375**	**$750**
Shoulder Blade or Collarbone (Scapula, Clavicle, Sternum)	**$450**	**$900**
Coccyx	**$300**	**$600**

Other Injuries Requiring Surgery

Abdominal or Thoracic Surgery	**$3,000**
Ruptured Disc/Tendons/Ligaments/Rotator Cuff/Torn Knee Cartilage	**$1,000**

Additional Accident Benefits

Dismemberment - Double Loss	**$15,000**
Dismemberment - Single Loss	**$7,500**
Dismemberment - One or more Fingers or Toes	**$1,500**
Transportation Maximum Per Trip - Max 3 Trips	**$300**
Wellness Benefit - 1 Test	**$100**
Hospital Sickness Rider - Max 90 days	**$250 / day**

Coverage Period - 24 hours (on and off the job)

Group Critical Illness

Critical Illness

A critical illness diagnosis, such as cancer, heart attack, stroke, or Alzheimer's disease, can be very difficult for the patient and their loved ones.

Canopy critical illness policies will pay a lump sum directly to you and your loved ones in the event of a covered diagnosis. These funds can be used for any expenses. This policy pays in addition to health insurance and other policies.

After your diagnosis, critical illness insurance provides support so you can focus on treatment instead of your finances.

The Facts

- One in two men and 1 in three women will be diagnosed with cancer during their lifetime[1]
- In 2022, 1,918,030 new cancer cases are projected to occur in the United States approximately 5,250 new cases a day1
- The 5-year survival rate for all cancers combined has increased substantially from approximately 50% in 1975 to over 70% in 2019[2]
- Between 2015 and 2018 126.9 million American adults had some form of Heart Disease, Stroke and other Cardiovascular Diseases (CVD)[3]

[1]American Cancer Society [2]American Cancer Institute [3]American Heart Association

Summary of Critical Illness Benefits

Benefit Plan Year: January 1, 2023 - December 31, 2023

A **Canopy Critical Illness Policy** provides a lump-sum cash benefit upon diagnosis of a specified critical illness such as Cancer, Heart Attack, Stroke, End Stage Renal Failure, Major Organ Transplant. The benefit is to help cover the out-of- pocket expenses associated with the critical illness and may be used for any expense so you can focus on recovery.

Benefit Highlights and Key Features

Guaranteed Issue	$5,000
Reoccurrence Benefit	100%
Pre-Existing Conditions Exclusion	12 months prior & 12 months after effective date

Covered Insured Benefit Amount

Insured	$5,000 - $40,000
Spouse	$2,500 - $20,000
Child	$1,250 - $10,000

Critical Illness - Benefit

Benefit payments by illness[1]

Cancer	Invasive	100%
	Benign Brain Tumor	100%
	Skin Cancer	$500
	Carcinoma	100%
	Carcinoma in Situ (not including Skin Cancer)	25%
Heart	Heart Attack	100%
	Coronary Artery Bypass Surgery	100%
	Angioplasty/Stent	25%
Stroke		100%
End-stage renal failure		100%
Major Organ Transplant		100%
Complete Sensory Loss	Loss of Sight	100%
	Loss of Hearing	100%
	Loss of Speech	100%
Coma		100%
Paralysis		100%
Addison's Disease		100%
Alzheimer's		100%
Amyotrophic Lateral Sclerosis (ALS)		100%
Cystic Fibrosis		100%
Huntington's Disease		100%
Multiple Sclerosis (MS)		100%
Muscular Dystrophy		100%
Parkinson's Disease		100%

[1] These benefits may be subject to pre-existing condition exclusion. Please review your certificate for more information.