

## ENROLLMENT FORM FOR GROUP INSURANCE

<b>GROUP NAME:</b>				<b>GROUP POLICY #</b>			
<b>A. Employee Information (Complete for ALL Enrollments)</b>							
Social Security Number		Last Name		First Name		MI	
Street Address			City		State	ZIP	Date of Birth
<input type="checkbox"/> Male	Marital Status	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced	Date of Full-Time Hire		Occupation	
<input type="checkbox"/> Female		<input type="checkbox"/> Single	<input type="checkbox"/> Widowed				
<b>B. Completed By Employer</b>							
Annual Earnings: \$				Average # Hours Worked Per Week:			
<b>C. Product Selection (Complete for ALL Enrollments)</b>							
<b>NOTE:</b> Please mark each box for coverage for which you are applying.							
Group Life AD&D		Dependent Life		Short Term Disability		Long Term Disability	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Family <input type="checkbox"/> No Coverage							
Vision: <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & 1 Dependent <input type="checkbox"/> Family <input type="checkbox"/> No Coverage							
<b>Voluntary Product Selection</b>							
Voluntary Life <input type="checkbox"/> Yes <input type="checkbox"/> No		Voluntary STD <input type="checkbox"/> Yes <input type="checkbox"/> No		Voluntary LTD <input type="checkbox"/> Yes <input type="checkbox"/> No			
Voluntary Dental <input type="checkbox"/> Yes <input type="checkbox"/> No			Voluntary Vision <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>D. Dependent Information (Dental or Vision Coverage) List Dependents to be Covered.</b>							
First Name		Last Name		Relationship		DOB	
First Name		Last Name		Relationship		DOB	
<b>E. Beneficiary Information (Complete ONLY for Life Enrollments)</b>							
Primary Beneficiary's Last Name			First	MI	Relationship of Beneficiary		Social Security Number
Contingent Beneficiary's Last Name			First	MI	Relationship of Beneficiary		Social Security Number
<b>F. REFUSAL OF COVERAGE (Complete ONLY for Waiver of Group Insurance Coverage)</b>							
The group program has been offered to me, and after carefully considering its benefits, I have decided: (Please indicate your choice) <input type="checkbox"/> (a) not to enroll myself or dependents in the Program <input type="checkbox"/> (b) not to enroll my dependents in the Program							

I understand that if I desire to participate in the Program at some future date, my coverage or my dependent's coverage will not be effective until after Evidence of Insurability is submitted and approved.

### G. Signature (Complete for Enrollment or Refusal)

I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. I reserve the right to revoke this deduction at any time on written notice.

Signature

Date

Print Name