



**ENROLLMENT FORM FOR GROUP INSURANCE**

OFFICE CODE:	Memo
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Please Use Ink or Type	GROUP ID:	GROUP POLICY #:
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**A. Employee Information (Complete for ALL Enrollments)**

Employer Name/Company Name (Please Print)		County	State
Social Security Number	Last Name	First Name	MI
Street Address		City	State
		Zip	Date of Birth
<input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed	Spouses Date of Birth	Home Phone ( ) Work Phone ( )

**Completed By Employer**

Effective Date:	Date of Full-Time Employment:	Occupation:
Earnings: \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly	<input type="checkbox"/> Union <input type="checkbox"/> Exempt <input type="checkbox"/> Non-Union <input type="checkbox"/> Non-Exempt	Average Hours Worked Per Week: Rehire Date:

**B. Product Selection (Complete for ALL Enrollments)**

Class	Effective Date	Basic Amount <i>Employer to Complete</i>	<b>NOTE:</b> Please mark each box if you are eligible for the listed coverage.		
			Coverage	Amount	Dental
			Group Life <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Single Dental
			Group AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> EE/Spouse
			Dependent Life <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> EE/Spouse/Children
			Optional Employee Life <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> EE/Children
			Optional Dependent Life <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> One Child
			Optional AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> 2 or More Children
			Long Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> No Coverage
			Short Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No		Effective: _____

**C. Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)**

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address		City		State
				Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address		City		State
				Zip

**Note:** A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

**D. Signature (Complete for ALL Enrollments)**

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.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date Signed

Dental Enrollment is on the back of this Enrollment Form.

**Waiver of Coverage:** Please sign and date this form where indicated below.

Please Use Ink or Type

GROUP ID: \_\_\_\_\_

**E. Dependent and Other Insurance Information (Complete ONLY for Dental Enrollment)**

List Dependents to be Covered for Dental Benefits (if applicable)

	Last Name	First Name	MI	Sex	Birth Date
EMPLOYEE:					
SPOUSE:					
CHILDREN:					

Are you or any of your eligible dependents covered by any other dental plan?  Yes  No If YES, please list:

Name of Insured	Insurance Company Name & Phone Number	Employer

Is coverage through other dental plan?  Single  Family

**F. WAIVER OF COVERAGE (Complete ONLY for Waiver of Group Insurance Coverage)**

The group program has been offered to me, and after carefully considering its benefits, I have decided:

(Please indicate your choice)

- (a) not to enroll myself or dependents in the Program  
 (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 dependents' coverage will not be effective until after Evidence of Insurability is submitted and approved. I understand if a physical examination or further medical information is required, it will be at my own expense.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date Signed

**Note: A person is guilty of insurance fraud if he or she submits an application or claim containing a false or deceptive statement with intent to defraud, or knowing that he or she is helping defraud, an insurance company.**