



ENROLLMENT FORM FOR GROUP INSURANCE

OFFICE CODE: _____ Memo

Please Use Ink or Type GROUP ID: _____ GROUP POLICY #: _____

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 Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Female <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"/> Union <input type="checkbox"/> Exempt <input type="checkbox"/> Non-Union <input type="checkbox"/> Non-Exempt | Average Hours Worked Per Week: |
| <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly | | Rehire Date: |

B. Product Selection (Complete for ALL Enrollments)

| Class | Effective Date | Basic Amount <i>Employer to Complete</i> | NOTE: 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.