

Group Employee Life/Disability Enrollment Form

Company

Location

Group No.

Section 1 – Employee Information

Employee Last Name <input type="text"/>	First Name <input type="text"/>	M.I. <input type="text"/>	Sex <input type="checkbox"/>	Birth Date (MM/DD/YY) <input type="text"/>	Social Security Number <input type="text"/>
Employee Home Address <input type="text"/>			Marital Status		Date of Marriage: MM/DD/YY <input type="text"/>
City <input type="text"/>	State <input type="text"/>	Zip Code <input type="text"/>	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Divorced		
Home Telephone Number <input type="text"/>					

Section 2 – Dependent Information *(Complete only if dependent coverage is elected)*

Spouse's Last Name <input type="text"/>	First Name <input type="text"/>	M.I. <input type="text"/>	Sex <input type="checkbox"/>	Birth Date (MM/DD/YY) <input type="text"/>
Children				
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>

Section 3 – Coverages Selected

Indicate type of coverage below. You may only elect coverages reflected in your Employer's contract. *(You will not be covered for coverages not included in your Employer's contract.)* To elect coverage check the box marked "Y". To decline coverage check the box marked "N".

Basic Life	Dependent Life	Supp Life / Amounts	AD/D	Weekly Disability	Long-term Disability
Y <input type="checkbox"/> N <input type="checkbox"/>	Spouse Y <input type="checkbox"/> N <input type="checkbox"/> Child Y <input type="checkbox"/> N <input type="checkbox"/>	Employee _____ Spouse _____	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>	Y <input type="checkbox"/> N <input type="checkbox"/>

Section 4– Beneficiary Designation

Full Name	Address	SSN	Relationship	D.O.B.
PRIMARY				
CONTINGENT				

Section 5 – Employee Signature

- I hereby apply for the coverages I have indicated above on behalf of myself and all dependents listed, and I authorize my Employer to make the appropriate deductions, if any, from my wages to pay for my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the Insurance Provider and my Employer.
- I hereby waive the coverages offered to me. I understand that if I desire to apply for any of these coverages at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability, that is satisfactory to the Insurance Provider before my coverage will become effective.

X

Employee Signature

Date Signed

Section 6 – To be Completed by the Employer

Employee Hire Date <input type="text"/>	Effective Date of Coverage <input type="text"/>	Salary \$ <input type="text"/>	<input type="checkbox"/> Annual <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly
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