



**GROUP INSURANCE ENROLLMENT FORM  
AND CHANGE REQUEST**

- |  |  |
|--|--|
| <input type="checkbox"/> New Employee          | <input type="checkbox"/> Change Address            |
| <input type="checkbox"/> Add/Increase Coverage | <input type="checkbox"/> Change Dependent Coverage |
| <input type="checkbox"/> Change Beneficiary    | <input type="checkbox"/> Change Class or Status    |
| <input type="checkbox"/> COBRA                 | <input type="checkbox"/> Terminate Coverage        |

**Companion Use Only**  
Approved:  Declined:   
Date: \_\_\_\_\_  
By: \_\_\_\_\_

<b>TO BE COMPLETED BY EMPLOYER</b>	Group No. (13 digit #)	DEPT/DIV	CLASS
Name of Employer (Use Name from Group Billing Notice or Master Application)			

**TO BE COMPLETED BY EMPLOYEES**

Social Security Number	Effective Date	Date Employed Full Time	Date of Birth	Hours Worked Per Week
	Month Day Year	Month Day Year	Month Day Year	

Your Name Last First M.I. Sex  Female  Male  Weekly  Monthly  Annually (Do not include over-time or bonuses.) Earnings \$ \_\_\_\_\_

Marital Status  Single  Married Occupation Your Home Address City State Zip Code

**COMPLETE FOR LIFE AND/OR DISABILITY** (If you decline coverage, complete the Refusal of Group Insurance section.)

COVERAGE REQUESTED  Basic Life Insurance  AD&D  Dependent Life Insurance  Short Term Disability  
 Long Term Disability  Voluntary LTD

Voluntary Life (Amount Selected) EMPLOYEE: Life \$ \_\_\_\_\_ AD&D \$ \_\_\_\_\_ SPOUSE: Life \$ \_\_\_\_\_ AD&D \$ \_\_\_\_\_ CHILD: Life \$ \_\_\_\_\_

Spouse Name: Last First Middle Birthdate Social Security Number  
(Voluntary Life Only)

Beneficiary for Employee Coverage/Relationship: (Employee is beneficiary for spouse coverage.)  
Last First Middle Relationship to Insured

**COMPLETE FOR DENTAL**

Is your spouse to be covered?  Yes  No

Dental Coverage Is For (Check Box Below):  
 Employee  Employee plus 1 (Spouse or Child)  Employee plus 2 (Spouse Child or 2 Children)  Employee plus 3 or more  
 (If you decline coverage, complete the Refusal of Group Insurance section.)

Are you covered by other dental insurance?  Yes  No

**Complete for Dependent Coverage**

Spouse Name (Last) (First) (Middle Initial)	Student Y/N	Date of Birth	Gender M or F	Do any of your dependents have any other dental coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Name of Carrier
CHILDREN		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	

**REFUSAL OF GROUP INSURANCE**

I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

Coverage Refused (Check All That Apply):  Basic Life  AD&D  Dependent Life  Voluntary Life  
 Short Term Disability  Long Term Disability  Voluntary LTD  Dental  Voluntary Dental

Date \_\_\_\_\_ Signature of Employee \_\_\_\_\_

**FRAUD WARNING (Not Applicable in AZ, FL, GA, MD, OR, VA):** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

**FRAUD WARNING (FL only):** Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

I elect the above coverage which I have checked from those for which I am eligible, and I decline the above coverage which I have not checked from those for which I am eligible. If any contribution from me is necessary to pay part of the cost of the insurance, I authorize my employer to deduct the contribution from my wages.

In regards to the section entitled COMPLETE FOR DENTAL, the following statement applies: "The policy provides dental benefits only. Review your certificate carefully."

Date	Your Signature
	X

**NOTICE TO PROPOSED INSURED – DETACH AND GIVE TO PROPOSED INSURED**

In connection with your application for insurance as part of our normal underwriting procedure, an investigative consumer report may be obtained, including, if applicable, information as to character, general reputation, personal characteristics and mode of living. This information is obtained through personal interviews with your friends, neighbors and associates. Upon written request, received within a reasonable time, additional, detailed information concerning the nature and scope of this investigation will be provided.