

THIS IS NOT AN APPLICATION FOR INSURANCE: This is an enrollment form.

Please complete both sides of this form to ensure a smooth enrollment. If you need assistance, please contact your plan administrator.

First name (please print)		M. initial	Last nam	e			
Social Security Number G	ender Date of b	ப் பெற்று Dirth (mm-dd-yy)	yy)			: : : : : : : : : : : : : : : : : : : 	
Street address						Apartme	ent #
City				State	ZIP code		
Original hire date Annı	ual salary	Occupation				Hou	rs worked
\$						per	week
Spouse first name (please print)		M. initial	Last nam	e			
Date of birth (mm/dd/yyyy)							
Stop 2: Choose a coverage amoun	nt (vou may uso th	o workshoot	to calcula	ato your cor	-+\		
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Step 3: Name your beneficiaries

Your primary beneficiary is the person (or persons) who will receive the benefit payment from your life insurance policy if you were to die. The total percent of benefit must not exceed 100%

First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
Your secondary beneficiary would receive the	benefit pay	ment from your life insurance policy if a prima	nry beneficiary is no longer living.	
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
First name (please print)	M. initial	Last name	Relationship (parent, child, friend, etc.)	% of benefit
Step 4: Sign and certify				
I have read and understand the "Exclusion Brochure. All statements are true to the b understand that a copy of this form will b authorize my employer to make the nece	est of my k e made ava ssary deduc	nowledge and belief. I Insura iilable to me at my request. I tions from my salary or wages No, I d	o not want coverage under Accide	
to pay the premium when my insurance be payroll deduction amount will change if m			& Dismemberment.	
made an error completing this form.	ly coverage	I unde	stand that if I elect coverage in th	o futuro
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Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Delayed Effective Date: if your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan. Exception: Infants are insured from live birth.

