



GROUP LIFE INSURANCE ENROLLMENT FORM

Please print or type all information. Signatures should be in blue or black ink.

POLICYHOLDER INFORMATION			
Group Policy Number:		<input type="checkbox"/> New Employee <input type="checkbox"/> Rehire <input type="checkbox"/> Retiree <input type="checkbox"/> Late Enrollee	
Employer Name:			
Employer Address:			
EMPLOYEE INFORMATION			
Last Name:	First Name:	M.I.:	Date of Birth:
			Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Social Security Number:	Occupation/Job Title:		Date of Hire:
Insurance Effective Date:		Basic Life Amount:	
Salary: <input type="checkbox"/> Annual \$ _____ <input type="checkbox"/> Hourly \$ _____ Hours Worked per Week ____ <input type="checkbox"/> Union <input type="checkbox"/> Non-Union	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Legally Separated	Dependent Information: Spouse's Name _____ Spouse's Date of Birth _____ Number of Dependent Children _____	
Benefit Elections: <input type="checkbox"/> I Elect <input type="checkbox"/> I decline Basic Employee Life and Accidental Death and Dismemberment <input type="checkbox"/> I Elect <input type="checkbox"/> I decline Basic Dependent Life		Optional Life (if applicable): Attach completed Proof of Good Health form for any amount requested. <input type="checkbox"/> I request Optional Employee Life coverage <input type="checkbox"/> I request Optional Dependent Life coverage	
Full Name of Primary Beneficiary:	Relationship:	Social Security Number:	Benefit Percentage:
Full Name of Primary Beneficiary:	Relationship:	Social Security Number:	Benefit Percentage:
Full Name of Contingent Beneficiary:	Relationship:	Social Security Number:	Benefit Percentage:
Full Name of Contingent Beneficiary:	Relationship:	Social Security Number:	Benefit Percentage:

I represent that the statements contained herein are true and complete to the best of my knowledge and belief. I understand that coverage is available to me based on the accuracy of my statements. I further understand that any misrepresentation on my part may be used as a basis for rescission of my coverage or denial of a claim.

I certify that I have been given the opportunity to participate in the coverage offered by my employer and I acknowledge that I may be required to contribute a portion of the cost for coverage selected and authorize automatic payroll deductions as required.

If coverage is declined and I wish to participate at a later date, I understand that my cost may be higher and evidence of insurability or a statement of good health may be required at my own expense as a condition for coverage.

Employee Signature:	Date:
Spouse's Signature (if required):	Date: