

<input type="checkbox"/> New Enrollee	<input type="checkbox"/> Change	<input type="checkbox"/> Decline coverage	Group #:
--	--	--	-----------------

Employer's Name

SECTION I. EMPLOYEE INFORMATION

Employee's Legal Name (First, MI, Last)				Social Security No.	
Home Address		City	State	Zip	Telephone No.
Date of Birth	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Salary \$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual		
Occupation (Be Exact)			Dept/Location		
Hours Worked Weekly			Date Employed Full-time		

PLAN INFORMATION - Ask your employer for the details about the cost, if any.

SECTION II. VOLUNTARY AD&D	Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage Applied for	Premium (Completed by Employer)
Voluntary AD&D: Employee	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Spouse	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Children	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

Do you intend to replace existing coverage with this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you actively at work on the date of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---

Dependents to be covered	Gender	Relationship	Social Security No.	Date of Birth
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			
	<input type="checkbox"/> M <input type="checkbox"/> F			

SECTION III. EMPLOYEE BENEFICIARY DESIGNATION Check if Change Only

This will revoke any existing beneficiary designations you may have for these benefits.

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of Employee):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

Total must equal 100% =

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if Primary Beneficiary(ies) are not living):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

Total must equal 100% =

I represent that the information provided above is true and correct. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. For coverage I have declined, I understand that if I choose to enroll at a later date, Evidence of Insurability may be required. If the Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

Warning - It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and a denial of insurance benefits in accordance with applicable state law.

Employee's Signature

Date

Date Received - Home Office

INSTRUCTIONS – How to Complete Section II

Initial Enrollment – Adding Coverage:

Check “Yes” by each coverage you want. Check “No” by each coverage you do not want.

If you checked “Yes” by a coverage, check the “Add New” box, and complete the “Total Amount of Coverage” for which you are applying.

For Example, you are applying for:

- Voluntary AD&D: \$100,000 on yourself; \$50,000 on your spouse, \$5,000 on your children

SECTION II. VOLUNTARY COVERAGE(S)			Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage	Premium (Completed by Employer)
A. Voluntary AD&D:	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$100,000	
	Spouse	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$50,000	
	Children	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$5,000	

How To Change or Delete Coverage:

If you are changing any of your coverage, please complete the information for all of the coverage you have, so that we are sure we have everything correct. Be sure to check the appropriate “Add,” “Delete,” “Increase,” or “Decrease” box.

For Example, you **currently** have:

- Voluntary AD&D: \$100,000 on yourself only and \$50,000 on your spouse

You want to **change** your coverage to:

- Voluntary AD&D: \$150,000 on yourself (increase) and no coverage on your spouse (delete)

SECTION II. VOLUNTARY COVERAGE(S)			Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage	Premium (Completed by Employer)
A. Voluntary AD&D:	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$150,000	
	Spouse	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	Children	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		