

<input type="checkbox"/> New Enrollee		<input type="checkbox"/> Change		<input type="checkbox"/> Decline all coverages		Group #:	
Employer: If Evidence of Insurability (EOI) is required, please submit the Evidence of Insurability form along with this enrollment form to us.							
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 - Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete Evidence of Insurability (EOI).							
SECTION II. VOLUNTARY COVERAGE(S) – SEE INSTRUCTIONS ON REVERSE OR PAGE 2							
Complete this Section if applying for these coverages. Evidence of Insurability may be required.				Add New	Delete	Increase Existing	Decrease Existing
A. Voluntary Group Life:							
Employee		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
Children		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Voluntary AD&D:							
Employee		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>(EOI not required)</i> Spouse		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>	<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"/>	<input type="checkbox"/>
C. Voluntary STD Income Protection (VIP):							
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	per week
D. Voluntary Long Term Disability:							
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	per month
Do you presently have other disability coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No				Do you have any existing life insurance policies or annuity contracts? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, give monthly amount \$ _____							
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					
Have you or your spouse (if applying for coverage) used tobacco products in the past year?				Employee <input type="checkbox"/> Yes <input type="checkbox"/> No			
				Spouse <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							
PRE-EXISTING CONDITIONS							
<ul style="list-style-type: none"> ▪ New Voluntary STD (VIP) plans and benefit increases: During the first year of your coverage, benefits will not be paid on any condition for which you received medical treatment or advice within 12 months before your effective date of coverage. ▪ New Voluntary LTD plans and benefit increases: During the first 2 years of your coverage, benefits will not be paid on any condition for which you received medical treatment or advice within 12 months before your effective date of coverage, unless you go 6 consecutive months treatment free. 							

I represent that the information provided on all pages of this enrollment form 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 those coverages 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.

Be sure to complete the Employee Beneficiary Designation on page 2/reverse side

Employee's Signature _____	Date _____
AGENT'S STATEMENT: To the best of your knowledge, does the applicant have any existing life insurance policies or annuity contracts? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Agent's Signature _____	Code No. _____
Date _____	Date Received - Home Office _____

Employee's Name (First, MI, Last)	Social Security #	Employer Name
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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% =

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 Group Life: \$50,000 on yourself, \$20,000 on your spouse, and no coverage on your children
- Voluntary AD&D: \$100,000 on yourself; \$50,000 on your spouse, \$5,000 on your children
- Voluntary LTD: \$2,000 per month

SECTION II. VOLUNTARY COVERAGE(S)		Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage	Premium (Completed by Employer)
Complete this Section if applying for these coverages. Evidence of Insurability may be required.							
A. Voluntary Group Life:	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$50,000	
	Spouse	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$20,000	
	Children	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
B. Voluntary AD&D:	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$100,000	
<i>(EOI not required)</i>	Spouse	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" 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"/>	\$5,000	
C. Voluntary STD Income Protection (VIP):		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	per week	
D. Voluntary Long Term Disability:		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$2,000 per month	

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 Group Life: \$60,000 on yourself, \$30,000 on your spouse, and \$10,000 coverage on your children
- Voluntary STD (VIP): \$300 per week

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

- Voluntary Group Life: \$100,000 on yourself (increase), \$20,000 on spouse (decrease), and no coverage for children (delete)
- Voluntary AD&D: \$100,000 on yourself only (add)
- Voluntary STD (VIP): \$300 per week (no change)

SECTION II. VOLUNTARY COVERAGE(S)		Add New	Delete	Increase Existing	Decrease Existing	Total Amount of Coverage	Premium (Completed by Employer)
Complete this Section if applying for these coverages. Evidence of Insurability may be required.							
A. Voluntary Group Life:	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	\$100,000	
	Spouse	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	\$20,000	
	Children	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>		
B. Voluntary AD&D:	Employee	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	\$100,000	
<i>(EOI not required)</i>	Spouse	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input 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"/>		
C. Voluntary STD Income Protection (VIP):		<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	300 per week	
D. Voluntary Long Term Disability:		<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	per month	