ENROLLMENT FORM

GENERAL INFORMATION SECTION

(Please complete entire section)

EMPLOYEE'S NAME (Last, First, M.I.)				М	SOCIAL SECURITY NUMBER			Tobacco	
				F				Non-Tobacco	
RESIDENCE ADDRESS			CITY			STATE ZIPCODE		CODE	
BIRTHDATE (MM/DD/YEAR) PHONE NUMBER		/IBER	EMPLOYEE'S EMAIL				□ Married		
								□ Single	
EMPLOYER/LOCATION if multiple locations			DATE HIRED (MM/DD/YEAR) OCCUPATION				ANNUAL SALARY		
SPOUSE NAME (Last, First, M.I.)		🗆 Tobacco		М	BIRTHDATE (MM/DD/YEAR)			DATE OF MARRIAGE	
		🗆 Non-Tobacco		F					
BENEFICIARY'S NAME (Last, First, M.I.)		RELATIONSHIP		Is your Spouse or Child Disabled?			YES NO		

PERSONS TO BE COVERED SECTION

(Please complete additional rows if dependent coverage is elected. Use additional paper if needed)

Name	Relationship	Sex	Date of Birth	Social Security	Used tobacco
(Last, First, M.I.)			(MM/DD/YEAR)	Number	in any form?
	Child			N/A	Y / N
	Child			N/A	Y / N
	Child			N/A	Y / N
	Child			N/A	Y / N
	Child			N/A	Y / N
	Child			N/A	Y / N

Deduction Frequency Option
Details Weekly - 52

✓ Bi-Weekly - 26

□ Semi-Monthly - 24

 \square Monthly - 12

First Deduction Date

Coverage Effective Date

Payroll Deduction

Additional Terms (please initial below):

_____ I authorize the above amount to be payroll deducted each pay period.

I have read and understand the Pre-Existing Condition clause associated with my policy.

I do not wish to participate and understand that future application for such insurance may require evidence of insurability.

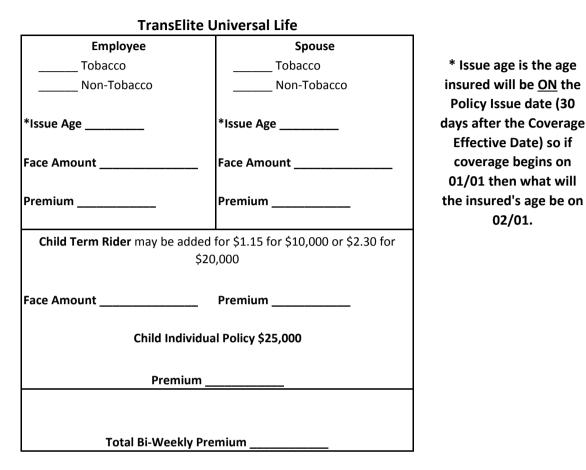
Signature:

Date: _____

Mothers Maiden Name: _____

Employer:_____

COVERAGE SECTION



If employee or spouse are applying for <u>OVER the Guaranteed Issue Amount</u> please answer the questions below.

1. In the past six months, has any proposed insured been hospitalized (inpatient or outpatient) or missed more than five consecutive days of work due to any accident or sickness, except for normal pregnancy?

Y/N

2. In the past five years, has any proposed been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?

Y/N

3. In the past five years, has any proposed insured been diagnosed or treated by a member of the medical profession for any heart (including heart attack), circulatory, vascular (including stroke), blood, brain, digestive, kidney, liver, lung, musculoskeletal, respiratory, rheumatoid, neurological, pancreas, reproductive, or other major organ disorders, cancer or malignancy in any form (except non-melanoma skin cancer), diabetes, Optic Neuritis, blood transfusion, chronic fatigue syndrome, fibromyalgia, high blood pressure requiring more than two medications to control, or been treated or counseled in the past two years for alcohol or drug abuse?

Y/N

