ENROLLMENT FORM

GENERAL INFORMATION SECTION

(Please complete entire section)

EMPLOYEE'S NAME (Last, First, M.I.)	☐ M ☐ F	SOCIAL SECURITY NUMBER	☐ Tobacco ☐ Non-Tobacco
RESIDENCE ADDRESS	CITY	STATE	ZIPCODE
BIRTHDATE (MM/DD/YEAR)	PHONE NUMBER	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 ☐ Non-Tobacco	☐ M ☐ F	BIRTHDATE (MM/DD/YEAR)	DATE OF MARRIAGE
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 (Last, First, M.I.)	Relationship	Sex	Date of Birth (MM/DD/YEAR)	Social Security Number	Used tobacco 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
- ☐ Weekly - 52
- ✓ Bi-Weekly - 26
- ☐ Semi-Monthly - 24
- ☐ 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: __________________________

Employee Name:____________________________ Employer:________________________________

COVERAGE SECTION

TransElite Universal Life

<table>
<tr><td>Employee
______ Tobacco
______ Non-Tobacco

*Issue Age _________

Face Amount _______________

Premium ____________</td><td>Spouse
______ Tobacco
______ Non-Tobacco

*Issue Age _________

Face Amount _______________

Premium ____________</td></tr>
<tr><td colspan="2">Child Term Rider may be added for $1.15 for $10,000 or $2.30 for $20,000

Face Amount _______________ Premium ____________

Child Individual Policy $25,000

Premium ____________</td></tr>
<tr><td colspan="2">Total Bi-Weekly Premium ____________</td></tr>
</table>

*** Issue age is the age insured will be ON the Policy Issue date (30 days after the Coverage Effective Date) so if coverage begins on 01/01 then what will the insured's age be on 02/01.**

If employee or spouse are applying for OVER the Guaranteed Issue Amount 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

4. **Employee**: Height ____ ft. ______ in Weight _______lbs. **Spouse**: Height ____ft. ____in Weight _______lbs.