APPLICATION FOR GROUP EMPLOYEE BENEFIT PLAN

(Please print in ink and press firmly)

❒ NEW ENROLLMENT
❒ TERMINATION ❒ LAYOFF ❒ NAME/ADDRESS CHANGE
❒ RE-ENROLLMENT ❒ REINSTATEMENT ❒ BENEFIT CHANGE

EMPLOYER DIVISION

EMPLOYEE LAST NAME FIRST INITIAL SOCIAL SECURITY NO.

MAILING ADDRESS CITY STATE ZIP

EMPLOYEE BIRTHDATE ❒ SINGLE ❒ DIVORCED ❒ LEGALLY SEPARATED SEX PHONE
❒ MARRIED ❒ WIDOW OR WIDOWER M F ( )

OCCUPATION SALARY LIFE AMOUNT PPO

HIRE/REINSTATED DATE TERMINATION DATE

APPLY FOR THE FOLLOWING COVERAGE

❒ NONE ❒ SHORT TERM DISABILITY ❒ LTD
❒ LIFE ❒ SUPP LIFE ❒ DEP. LIFE

MEDICAL	DENTAL	VISION	DRUG	
❒	❒	❒	❒	NONE
❒	❒	❒	❒	EMPLOYEE ONLY
❒	❒	❒	❒	EMPLOYEE AND CHILDREN
❒	❒	❒	❒	EMPLOYEE AND SPOUSE
❒	❒	❒	❒	EMPLOYEE AND FAMILY

BENEFICIARY

	LAST NAME	FIRST	INITIAL	RELATIONSHIP
PRIMARY				
SECONDARY				

DEPENDENT INFORMATION

LAST NAME	FIRST	INITIAL	BIRTH DATE	SEX	EFFECTIVE DATE	RELATIONSHIP	TERMINATION DATE

WAIVER OF COVERAGE - HEALTH COVERAGE NOT APPLIED FOR BECAUSE:

_____ APPLICANT IS COVERED AS DEPENDENT UNDER ANOTHER PLAN
_____ APPLICANT IS AGE 65-69 AND ELECTS TO BE COVERED ONLY BY MEDICARE (NO BENEFITS WILL BE AVAILABLE UNDER THIS PLAN FOR THE EMPLOYEE AND HIS SPOUSE.)

SIGNATURE _____

OTHER COVERAGE

ARE YOU OR YOUR DEPENDENTS COVERED UNDER ANY OTHER GROUP PLAN? ❒ YES ❒ NO IF SO, PLEASE PROVIDE THE FOLLOWING INFORMATION

NAME OF PERSON COVERED EMPLOYED BY

OTHER INSURANCE

GROUP PLAN NAME

INSURANCE ADDRESS

POLICY PLAN NUMBER	TYPE OF COVERAGE S/SINGLE F/FAMILY	MEDICAL S F	DENTAL S F	VISION S F	DRUG S F

EMPLOYER'S SECTION

FILL IN EFFECTIVE CHANGE DATE(S)

CLASS/LIFE AMT	SUPP/LIFE	LIFE DATE	MEDICAL DATE	DENTAL DATE	STD DATE	VISION DATE	COBRA DATE	DEP LIFE DATE	LTD DATE	DRUG DATE
COVERAGE TYPE-USE DESIGNATED CODES			MEDICAL	DENTAL	STD	VISION	COBRA	DEP LIFE	LTD	DRUG

Refusal:
The benefits have been explained to me and I have refused to participate in the Plan. I have signed the attached Declination of Coverage and Special Enrollment Rights Form. If I apply at a later date, I understand supplemental coverages, with the exception of medical and dental plans, will be subject to evidence of insurability.
Employee's Signature _____ Date _____