

Application for Insurance

	Underwritte								Certifica	
	•				•		iroup #	Effecti	ve Date	
1 Last Name			First Name				Birth Date			
2 Age	Male □ Female □	Height	We	eight	Social Security #		Cell/Home Phone			
3 Street					Cit	у	State	ZIF	^o Code	
4 Employer				Location			Occupation			
5 Salary \$		I Hourly □ Bi- I Weekly □ N	Weekly Nonthly	☐ Annually We	ekly Hours rked	Work Phone/Ext.			Hire Date	
6 Payroll Γ	Deduction Frequenc	y: 🗖 Weekly	/ 🖵 Bi-	Weekly 🖵 Sen	ni-Monthly	☐ Monthly				
					-	and Long Term Dis				
		Amount	olumn a	ana inaicate if	ndicate if coverage is: (N) New STD Amount			(I) Increase (D) Decrease		
•	N/I/D Benefit Ar	nount F	remium	N/I/D	Benefit Amou	ınt Premium	N/I/D	Benefit Amou	nt Premium	
Employee	\$	\$		\$		\$			\$	
	\$:\$			pe	per: □ Wk □ Mo			per: 🗆 Wk 🗔 Mo		
Spouse	Ψ	Ψ			Benefit Period:			Benefit Period:		
Child(ren) \$		\$			Elimination Period:			Elimination Period:		
,	!			STU at	STD and LTD benefit amounts must be in mu			ultiples of \$25 units (not to exceed maximum benefit).		
	•	tain to Spo				ons 9, 10 and 11 p				
luestions	8, 9 and 10 per	tain to Spo	Duse a	nd Children Birth Date	. Questio	ons 9, 10 and 11 p	ertain to E	mployee (Only Coverage	
luestions	•	tain to Spo								
Questions Spouse	•	tain to Spo								
Questions Spouse Child Child	•		Age	Birth Date	Sex		Height		Last 4 digits SS	
Buestions Spouse Child Child Have you	Name Name	used tobaco	Age	Birth Date	Sex t year?	Place of Birth Employee: Yes	Height No Spo	Weight use: □ Yes	Last 4 digits SS	
Buestions Spouse Child Child Have you	Name ou or your spouse all proposed insur	used tobaco	Age co prod e/spous	Birth Date ucts in the last se/child(ren) ac	Sex t year? E	Place of Birth	Height No Spo memaker, or	Weight use: □ Yes	Last 4 digits SS	
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In absence of fraud, my answers in this enrollment form shall be deemed representations and not warranties. If any data has been misstated, the correct data will be used to determine if insurance is in force. If insurance is in force, the premium and/or benefits will be adjusted according to the facts.

I understand that "pre-existing conditions" are generally not covered under the coverage(s) applied for and I should read my Certificate for a more detailed explanation of the pre-existing exclusion.

I understand that other income that I am entitled to receive may affect my coverage and I should read my Certificate for more detailed information regarding the effect other income may have on my benefit.

I certify under penalties of perjury that the portion of the Social Security Number shown on page 1 of this enrollment form is correct to the best of my knowledge and I am not subject to backup withholding.

The insurance applied for shall be in force as of the date of the payroll deduction authorization signed by me, provided that the company approves the enrollment form without any modification as to the plan, amount or premium, and, further provided that the company receives the first premium payment from my employer within 90 days from the date hereof. If the first premium is not received within 90 days, no insurance will become effective. If the enrollment form is approved with any such modification, the insurance shall not take effect until the certificate has been delivered to and accepted by me and furthermore shall not take effect if there has been a change in the health of any person to be insured as stated since the date of enrollment form.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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Signature of Employee	Date	Signed at (City, State)