# Group Insurance Enrollment Card

| CERT. NO. | POLICY NUMBER |
|---|---|
| COMPANY USE | |

**MUST BE ANSWERED FOR ALL PLANS.**

| INSURED'S LAST NAME | FIRST NAME | MIDDLE INITIAL | SEX ☐ M ☐ F | DATE OF BIRTH MO. DAY YEAR |
|---|---|---|---|---|

| MY OCCUPATION | NAME OF MY EMPLOYER |
|---|---|

| AMOUNT OF EARNINGS $ ☐ Hr. ☐ Wk. ☐ Mo. ☐ Yr. | FULL-TIME EMPLOYMENT DATE MO. DAY YEAR | SOCIAL SECURITY NO. |
|---|---|---|

**FILL IN WHEN GROUP POLICY PROVIDES DEPENDENT BENEFIT**

Do you have eligible Dependents? ☐ Yes ☐ No
Check dependents you wish to insure
☐ Spouse ☐ Children ☐ None

Spouse's Signature ______
Dependent Age 18 Or Older Signature ______

SPOUSE'S DATE OF BIRTH
MO. DAY YEAR

**IF PLAN REQUIRES PAYROLL DEDUCTIONS COMPLETE THIS PORTION**

CONTRIBUTORY LIFE ☐ Yes ☐ No INSURANCE AMOUNT $ ______
WEEKLY INDEMNITY ☐ Yes ☐ No LONG TERM DISABILITY ☐ Yes ☐ No

**IF PLAN PROVIDES LIFE, OR ACCIDENTAL DEATH INSURANCE, COMPLETE THIS PORTION**

| | BENEFICIARY'S LAST NAME | FIRST NAME | MIDDLE INITIAL | AGE | RELATIONSHIP TO EMPLOYEE |
|---|---|---|---|---|---|
| Primary | | | | | |
| Contingent | | | | | |

Your benefits will be paid first to the Primary beneficiary(ies). If that person(s) is deceased, benefits will be paid to the Contingent

**PLEASE READ, DATE AND SIGN THIS PORTION**

I am an active, full-time employee. The complete terms of the group insurance coverage will be set forth in the group insurance policy(ies). If my employer requires contributions for the insurance I have selected, I authorize my employer to deduct such contributions from my wages.

______ Date Signed

______ Signature of Employee

Form 1.558 08/2011

REMARKS:

| INSURANCE EFFECTIVE DATE | INSURANCE CLASS | LIFE AMOUNT | AD&D AMOUNT | | WEEKLY INDEMNITY BENEFIT | LTD BENEFIT | |
|---|---|---|---|---|---|---|---|
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| TERMINATION DATE | REINSTATEMENT DATE | DATE OF DEATH | DATE WAIVER OF PREMIUM APPROVED |
|---|---|---|---|
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