

☐ New Enrollment	☐ Change	Enrol	Iment	Form
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SCOVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits satisfied below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnairs. COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits satisfied below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnairs. BASIC COVERAGE(S) Basic LinkADAD in 75 Benefit and Critical linkess insurance) In 8D In 15 Benefit and Critical linkess insurance) Voluntary Term Life: Spouse Voluntary Term Life: Spouse Voluntary Term Life: Spouse Voluntary Term Life: Spouse Voluntary Term Life: Dependent Child(ren) Voluntary Term Disability - for Earnings Voluntary Term Disability - for Earnings Voluntary Short-Term Disability - incremental VES No Voluntary Short-Term Disability - for Earnings Voluntary Short-Term Disability - for Earnings Voluntary Long-Term Disability - for Earnings Voluntary Long-Term Disability - for Earnings Review the following guidelines which apply to voluntary coverage(s) * Review the following a scheduled enrollment period. * Park John Short-Term Disability - for Earnings * Review the following a scheduled enrollment period. * Now Youthany STD plans and benefit increases are subject to a 12/12 pre-existing condition limitation (3/12 in PA). * BENEFICIARY STD plans and benefit sort your in a scheduled enrollment period. * Now You may arroll, apply for additional coverage, or requests a change to current voluntary benefits only during a scheduled enrollment period. * Now Youthany STD plans and benefit increases are subject to a 12/12 pre-existing condition limitation (3/12 in PA). * BENEFICIARY STD plans and benefit increases are subject to a 12/12 pre-existing condition limitation (3/12 in PA). * Review the following subject in the sate of the following su	EMPLOYER: If group is self-administered, submit enrollment form only if evidence of insurability is required. If group is not self administered, submit enrollment form to us.											
S		YEE NAME — LAST FIRST MIDDLE IN		INITIAL			ATE OF BIRTH	DATE OF H	DATE OF HIRE (FULL TIME)			
GOVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire. BASIC COVERAGE(S) Basic LIADADA STO Security LTD Security Department LTD BASIC COVERAGE(S) (Evidence of Insurablely may be required to complete a health questionnaire. VOLUNTARY COVERAGE(S) (Evidence of Insurablely may be required to complete a health questionnaire. VOLUNTARY COVERAGE(S) (Evidence of Insurablely may be required to complete a health questionnaire. VOLUNTARY COVERAGE(S) (Evidence of Insurablely may be required to complete a health questionnaire. VOLUNTARY COVERAGE(S) (Evidence of Insurablely may be required to complete a health questionnaire. VOLUNTARY COVERAGE(S) (Evidence of Insurablely may be required to complete a health questionnaire. VOLUNTARY COVERAGE(S) (Evidence of Insurablely may be required to employee and spouse Ltdl and Critical liness Insurance) VOLUNTARY COVERAGE(S) (Evidence of Insurablely may be required to employee and spouse Ltdl and Critical liness Insurance) VOLUNTARY COVERAGE(S) (Evidence of Insurable May be required to employee and spouse Ltdl and Critical liness Insurance) VOLUNTARY COVERAGE(S) (Evidence of Insurable May be required to employee and spouse Ltdl and Critical liness Insurance) VOLUNTARY COVERAGE(S) (Evidence of Insurable May be required to employee and spouse Ltdl and Critical liness Insurance) Voluntary Term Life: Employee Voluntary Short-Term Disability -% of Earnings VES NO Voluntary Short-Term Disability -% of Earnings VES NO Voluntary Short-Term Disability -% of Earnings VES NO Voluntary LTD and Critical Short Short Short Short Short Short Short Short	SOCIAL SECURITY NO. (THIS	IS YOUR CERTIFICAT	·	INGS		_	' I	LE		C	LASS	
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Sease LinkAlbe PKS NO Order PKS PKS NO Order PKS PKS NO Order PKS PKS PKS NO Order PKS	BASIC COVERAGE(S)				Supplemen	tal Life	Sup	pplemental AD&D	Other _		
VOLUNTARY COVERAGE(S) (Evidence of Insurability may be required on employee and spouse Life and Critical illness insurance) (A)did (C)hange (O)elete Total Amount of Coverage was Voluntary Term Life: Employee YES NO			Benefit	Depen	dent Life	☐ Add ☐	Change 🗌] Del. 🗆 🗀 A	Add 🗌 Change 🔲	Del. Yes	□ No	
Cichange Cichange Applied for Coverage If (C), my prior coverage was Voluntary Term Life: Employee VES NO Voluntary Term Life: Spouse VYES NO Voluntary Term Life: Dependent Child(ren) VYES NO Voluntary Term Life: Dependent Child(ren) VYES NO Voluntary AD&D: Individual Family NO Voluntary AD&D: Individual Family NO Voluntary Short-Term Disability - Incremental VYES NO Voluntary Long-Term Disability - Nortemental Nor				•		\$		\$		\$		
Voluntary Term Life: Spouse YES NO	VOLUNTARY COVERAGE(S) (Evidence of Insurability may be required on employee and spouse Life and Critical Illness Insurance)				(C)h	(C)hange		of Coverage If				
Voluntary Term Life: Dependent Child(ren)	Voluntary Term Life: E	mployee		☐ YE	S 🗆 NO							
Voluntary AD&D: Individual Family MO	Voluntary Term Life: S	pouse		☐ YE	S 🗆 NO							
Voluntary Short-Term Disability - incremental YES NO	Voluntary Term Life: D	ependent Child(ren)	☐ YE	S 🗆 NO						_	
Voluntary Short-Term Disability - % of Earnings YES NO	Voluntary AD&D:	□ Inc	dividual 🗆	Family	, 🗆 NO							
Voluntary Long-Term Disability - Incremental YES NO	Voluntary Short-Term I	Disability - Incre	mental	☐ YE	S 🗆 NO							
Voluntary Long-Term Disability - % of Earnings	Voluntary Short-Term I	Disability - % of	Earnings	☐ YE	S 🗆 NO							
SPOUSE NAME - LAST FIRST M.I. SK SPOUSE DATE OF BIRTH SPOUSE SOCIAL SECURITY #	Voluntary Long-Term D	Disability - Incre	mental	☐ YE	S 🗆 NO							
Has Employee (if applicant) used cigarettes or other tobacco products in the last 2 years? YES NO NO In the last 2 years? YES NO NO NO NO NO NO NO N		-		☐ YE	S 🗆 NO							
Review the following guidelines which apply to voluntary coverage(s)* **You may enroll, apply for additional coverage, or request a change to current voluntary benefits only during a scheduled enrollment period. **If you are eligible for state-mandated temporary disability benefits, or any employer sponsored income replacement benefits, the combination of your state mandated benefit or other income benefit and your STD weekly benefit may not exceed 60% of your basic weekly earnings. **New Voluntary LTD plans and benefit increases are subject to a 12/12 pre-existing condition limitation (3/12 in PA). **BENEFICIARY DESIGNATION (For Employee Only: Must Be Completed if you have applied for life or AD&D insurance). If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary benefities who survives you. If no primary beneficiary survives you, proceeds will be paid in equal shares to the named primary benefities who survives you. The notate of the intervives you, proceeds will be paid in equal shares to the named primary benefities who survives you. Primary **BINAME LAST NAME** DATE OF BIRTH** RELATIONSHIP** SOCIAL SECURITY #* BENEFIT %* **Primary** Primary** **Contingent** **Interport of the date disability begins.** **DATE OF BIRTH** **RELATIONSHIP** SOCIAL SECURITY #* BENEFIT TO WHICH I MAY BE ENTITLED UNDER THE GROUP POLICY (IES) ISSUED TO THE EMPLOYER LISTED ABOVE. I UNDERSTAND THAT IF I AM NOT ACTIVELY AT WORK AS DEFINED IN THE POLICY ON THE DATE MY COST MAY BE HIGHER AND A HALTHO DUEST IONALISE MY SOLICE HAVE DECLINED, I UNDERSTAND THAT IF I CHOOSE TO ENROLL AT A LATER DATE. MY COST MAY BE HIGHER AND A HEALTH OUEST INDAHABLE MAY BE REQUIRED. **ANY PERSON WHO KNOWINGLY and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact mate		FIRS	ST	M.I.		SPOUSE DATE OF BIRTH SPOUSE SOCIAL SECURITY #						
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