

Enrollment Form

For group coverage – life only



www.advanceinsurance.com

Section 1

Name _____
Last (Sr., Jr., etc.) First MI

Residential Address _____
Street

City _____ State _____ ZIP Code + 4 _____

Mailing Address _____
If different from residential address Street

City _____ State _____ ZIP Code + 4 _____

Married? Yes No Date of Marriage _____
MM DD YYYY

Employed by _____

Actively working _____ hrs weekly for this employer

Date of Birth _____
MM DD YYYY

Social Security No. _____

Gender Male Female

Home Phone _____
Area Code

Work Phone _____
Area Code

Cell Phone _____
Area Code

Group No. _____

Date of Full-Time Hire _____
MM DD YYYY

Section 2

Reason for change in employment: part time to full time temporary to permanent rehire/recall other (specify) _____
 Date this occurred _____
MM DD YYYY

Employee Occupation/Job Title _____		Earnings \$ _____ <input type="checkbox"/> HR <input type="checkbox"/> WK <input type="checkbox"/> MO <input type="checkbox"/> ANN	Eligible unmarried dependent children under 23? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently working for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does your spouse work for this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Applying for: <input type="checkbox"/> Yes <input type="checkbox"/> No	Dependent Life <input type="checkbox"/> Yes <input type="checkbox"/> No
		Short Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Long Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No

	Last	First	M.I.	Street	City	State	Relationship	Age
Primary Beneficiary	1							
	2							
Contingent Beneficiary	1							
	2							

If this space is inadequate for your beneficiary(ies), attach a separate signed and dated list providing complete information.

Section 3

Beneficiary Tips

- A primary beneficiary will receive death proceeds upon the death of the insured.
- A contingent beneficiary will receive death proceeds only if primary beneficiary(ies) are deceased.
- The form must be signed and dated to be valid.

I understand that if I am not at work on the effective date of my coverage, my life and/or disability (if applicable) insurance will not begin until the day I return to work. If I do not enroll when first eligible, I understand evidence of insurability will be required, that I will be responsible for any fees or cost associated with the physical or for obtaining medical records as a late enrollee and that life and/or disability (if applicable) insurance coverage may be declined.

Your signature & date required _____

Date _____