



ENROLLMENT FORM

*** PLEASE PRINT CLEARLY WHEN FILLING OUT THIS FORM ***

EMPLOYER INFORMATION (To be entered by company representative)

Employer Name: _____ Date of Hire: _____

Employer Address: _____ Employee Status: Hourly
 Street 1: _____ Salaried
 Street 2: _____ Retired

City: _____ State: _____ Zip Code: _____

ENROLLEE INFORMATION (To be filled out by employee)

Employee Name: _____ Date of Birth: _____

Employee Address: _____ Social Security Number: _____

Street 1: _____ Marital Status: Single
 Street 2: _____ Married

City: _____ State: _____ Zip Code: _____

WAIVER OF ENROLLMENT: I elect not to participate in the Plan at the present time.

Signature: _____ Date: _____

PLAN OPTIONS

<u>Select Plan Option(s) below:</u>	<u>Requested Coverage (select one):</u>
	<input type="checkbox"/> Employee Only
	<input type="checkbox"/> Employee & Spouse
	<input type="checkbox"/> Employee & Child(ren)
	<input type="checkbox"/> Family

PERSON(S) COVERED:							
Last Name	First Name	MI	Sex	DOB	SSN#	Relation	Student *
Employee:							
Dependents:							

* If a dependent is over age 19, you must submit proof of full-time enrollment at an accredited school, college or university.
 The Applicant represents that he/she has read each question and that the answers are complete and true to the best of his/her knowledge or belief. The proposed rates shall take effect as of the requested effective date if this application is accepted. In the event that the application is not accepted, any premium advanced shall be refunded.
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 material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Enrollee Signature: _____ Date: _____