

EMPLOYEE – MUST ALWAYS BE COMPLETED

NAME _____
 Please Print (first) (middle) (last)

Residence Address _____ (street/box no.)

City _____ State _____ Zip _____

Social Security Number _____ - _____

Birthdate _____ Date of Hire _____ Sex _____

Budget Code _____ Daytime Phone No. _____

Employee Annual Base Salary \$ _____

SPOUSE – (Always show name-Fully Complete for Coverage)

NAME _____
 Please Print (first) (middle) (last)

Residence Address _____ (street/box no.)

City _____ State _____ Zip _____

Social Security Number _____ - _____

Birthdate _____ Sex _____

Has spouse been hospitalized, advised to seek medical treatment, or received disability benefits during the last 6 months? Yes No
 If yes, submit supplemental application.

CERTIFICATE INFORMATION - EMPLOYEE

Employee Coverage Amount: \$ _____
 Minimum - \$5,000
 Maximum - Five times your annual base salary, rounded to next higher multiple of \$5,000 up to \$300,000. A supplemental application must be completed and submitted for amounts over three times annual base salary.

Beneficiary _____ Relationship _____

Address _____

Children's Coverage: \$2,500 \$5,000
 Coverage available on either employee or spouse certificate, but not both. However, if employee purchases coverage, children's coverage must be attached to that certificate.

CERTIFICATE INFORMATION - SPOUSE

Spouse Coverage Amount: \$ _____
 Minimum - All Ages: \$5,000
 Maximum - Less Than Age 55: \$15,000 or one times employee annual base salary in multiples of \$5,000 up to \$30,000.
 Maximum - Ages 55 and Over: \$15,000

Beneficiary _____ Relationship _____

Address _____

Children's Coverage: \$2,500 \$5,000
 Coverage available on either employee or spouse certificate, but not both. However, if employee purchases coverage, children's coverage must be attached to that certificate.

List eligible dependent children as defined in the plan.

COMPLETE ONLY IF DEPENDENT CHILDREN'S TERM INSURANCE CHOSEN ABOVE.

(First)	Child's Name		Social Security Number	Date of Birth			Issue Age	Sex M or F	Relationship to Employee
	(Middle)	(Last)		Mo	Day	Year			
			- -						
			- -						
			- -						

The beneficiary of children's term insurance is the employee, if living, otherwise the estate of the covered child.

I certify that the information on this application is true and complete and that I am Actively at Work/Positive Pay Status on the date of my signature below. I understand that if I have selected insurance for myself, it will begin on the Certificate Issue Date; provided I am Actively at Work/Positive Pay Status on that date.

Dependent Spouse and/or Dependent Children's Coverage, if selected, will begin on the Certificate Issue Date; provided: (1) I am Actively at Work/Positive Pay Status on that date; and (2) my Dependent Spouse and/or Dependent Child(ren) is/are able to engage in normal activities on the date the coverage is to become effective.

I understand that I, as the Employee, am the owner of all coverages applied for. I authorize my Employer to deduct the proper premiums for this insurance from my earnings.

Any person who, knowingly and with intent to defraud or deceive any insurance company, submits an insurance application or files a claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending upon state law.

Employee Signature _____ Date _____

Agency Name _____ Budget Code _____

Agency Benefits Coordinator Signature _____ Date _____

Email Address _____ Phone _____

Agency Benefits Coordinator Signature above verifies applicant's eligibility for life coverage.

FOR HOME OFFICE USE ONLY

DEDUCTION AMOUNT: E _____ S _____ C _____ TD _____