GROUP TERM LIFE ENROLLMENT FORM

EMPLOYER: Meade School District		POLICY # GL1327	TO BE COMPLETED BY POLICY OWNER
DATE OF EMPLOYMENT 1-1-2017	NEW ENROLLMENT XX CHANGE IN COVERAGE ONLY ____	BASIC LIFE $20,000	

NAME OF EMPLOYEE

LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY #	BIRTHDATE	GENDER

RESIDENCE ADDRESS

STREET	CITY	STATE	ZIP CODE

PRIMARY BENEFICIARY(IES)				CONTINGENT BENEFICIARY(IES)			
LAST NAME	FIRST NAME	MI	RELATIONSHIP	LAST NAME	FIRST NAME	MI	RELATIONSHIP
LAST NAME	FIRST NAME	MI	RELATIONSHIP	LAST NAME	FIRST NAME	MI	RELATIONSHIP
LAST NAME	FIRST NAME	MI	RELATIONSHIP	LAST NAME	FIRST NAME	MI	RELATIONSHIP

☐ I elect Supplemental Employee Life/AD&D $ ________ Amount (multiples of $10,000 to $500,000)	☐ I elect Supplemental Spouse Life $ ________ Amount (multiples of $10,000 to $500,000)	☐ I elect Supplemental Child Life ☐ $5,000 ☐ $10,000	☐ I elect Supplemental Family AD&D *Employee amount equals Supp Life *Spouse 50%, Children 10%
☐ I decline Supplemental Employee Life/AD&D	☐ I decline Supplemental Spouse Life	☐ I decline Supplemental Child Life	☐ I decline Supplemental Family AD&D

If the above elect or decline boxes are left blank, coverage will be considered declined.

I've been told about, understand and request (or refuse as indicated) the insurance under the group insurance policy issued by EMC National Life to my employer. I authorize payroll deduction for supplemental insurance I elect. I understand that even though I have elected the insurance provided, Medical Evidence of Insurability may be required. Late applicants are always subject to proof of good health. Insurance will not take effect until approved by EMC National Life.

NOTE: The Company is relying on the information in this application to qualify all persons proposed for coverage under this insurance policy. Any false statement or misrepresentation may result in loss of coverage under this policy. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

VERIFICATION: To the best of my knowledge, all information shown is correct, and by signing this form I am indicating that I understand all information given is subject to verification.

SIGNATURE OF EMPLOYEE ______________________ DATE COMPLETED ____________

HOME OFFICE USE ONLY

LH707.02