PRESS FIRMLY • USE BALL POINT PEN • PRINT LEGIBLY

APPLICATION FOR GROUP EMPLOYEE BENEFIT PLAN

MY EMPLOYER	GROUP NUMBER	ACCOUNTING CODE

LAST NAME	FIRST	MIDDLE	SEX	BIRTHDATE	SOCIAL SECURITY NUMBER

EMPLOYEE'S MAILING ADDRESS	CITY	STATE	ZIP

TELEPHONE	HIRE/FULL-TIME DATE	JOB TITLE	PAYROLL		MARITAL STATUS			
			Hourly	Salary	Single	Married	Divorced	Widowed

ARE YOU OR ANY MEMBER OF YOUR FAMILY COVERED BY ANY OTHER MEDICAL INSURANCE PLAN NO YES
IF YES, OTHER INSURANCE NAME AND ADDRESS:

BENEFICIARY(S)	RELATIONSHIP

DEPENDENT INFORMATION:

If you indicated DEPENDENT COVERAGE, please list spouse/children below. If dependent benefits are declined please complete WAIVER below.

A=Add D=Drop	LAST NAME FIRST	BIRTHDATE	SEX	SOCIAL SECURITY #	S=Student E=Employed H=Handicapped	RELATIONSHIP
	01 SPOUSE					
	01 CHILD					
	02 CHILD					
	03 CHILD					
	04 CHILD					
	05 CHILD					
	06 CHILD					
	07 CHILD					

PLAN AND BENEFITS APPLIED FOR:

New Change

Plan: Medical

A B C D

Dental

Vision

Coverage For: Employee Only
Employee & Spouse
Employee & Children
Family

Decline For: Self
Spouse
Children

I request the benefits indicated above, and agree to the necessary payroll deductions, if any, for the coverage. I authorize the release of any medical or other records or information necessary to process this application, or to consider claims under this plan.

X

SIGNATURE DATE