

**GROUP INSURANCE ENROLLMENT FORM
AND CHANGE REQUEST**



P.O. Box 100102 • Columbia, S.C. 29202
800-753-0404 (Phone) • 800-836-5433 (Fax)

- | | |
|--|--|
| <input type="checkbox"/> New Employee | <input type="checkbox"/> Change Address |
| <input type="checkbox"/> Add/Increase Coverage | <input type="checkbox"/> Change Dependent Coverage |
| <input type="checkbox"/> Change Beneficiary | <input type="checkbox"/> Change Class or Status |
| <input type="checkbox"/> COBRA | <input type="checkbox"/> Terminate Coverage |

Companion Use Only
Approved: Declined:
Date: _____
By: _____

TO BE COMPLETED BY EMPLOYER		Group No.	DEPT/DIV	CLASS
Name of Employer (Use Name from Group Billing Notice or Master Application)				

TO BE COMPLETED BY EMPLOYEES												
Social Security Number			Effective Date			Date Employed Full Time			Date of Birth			Hours Worked Per Week
			Month	Day	Year	Month	Day	Year	Month	Day	Year	
Your Name	Last	First	M.I.	Sex	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually (Do not include over-time or bonuses.)							
				<input type="checkbox"/> Female <input type="checkbox"/> Male	Earnings \$ _____							
Marital Status	Occupation	Your Home Address			City	State	Zip Code					
<input type="checkbox"/> Single <input type="checkbox"/> Married												

COMPLETE FOR LIFE AND/OR DISABILITY									
COVERAGE REQUESTED <input type="checkbox"/> Basic Life Insurance <input type="checkbox"/> AD&D <input type="checkbox"/> Dependent Life Insurance <input type="checkbox"/> Short Term Disability									
<input type="checkbox"/> Long Term Disability <input type="checkbox"/> Voluntary LTD									
<input type="checkbox"/> Voluntary Life	Life	AD&D	Life	AD&D	Life				
(Amount Selected)	EMPLOYEE: \$ _____	\$ _____	SPOUSE: \$ _____	\$ _____	CHILD: \$ _____				
Spouse Name:	Last	First	Middle	Birthdate	Social Security Number				
<i>(Voluntary Life Only)</i>									
Beneficiary for Employee Coverage/Relationship: <i>(Employee is beneficiary for spouse coverage.)</i>									
Last	First	Middle	Relationship to Insured						

COMPLETE FOR DENTAL AND/OR VISION	
Coverage Requested:	<input type="checkbox"/> Dental For Employee Only <input type="checkbox"/> Dental For Employee and Dependents <input type="checkbox"/> Vision For Employee Only <input type="checkbox"/> Vision For Employee and Dependents

Is your spouse to be covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Dental and/or Vision Coverage Is For (Check Box Below):				Are you or any of your dependents covered for dental insurance under another policy? <input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Employee	<input type="checkbox"/> Employee plus 1 <input type="checkbox"/> Spouse or <input type="checkbox"/> Child	<input type="checkbox"/> Employee plus 2 <input type="checkbox"/> Spouse <input type="checkbox"/> Child or <input type="checkbox"/> 2 Children	<input type="checkbox"/> Employee plus 3 or more	

Complete for Dependent Coverage			Full-time Student	Date of Birth	Gender	Do any of your dependents have any other dental coverage?	If Yes, Name of Carrier
Spouse Name	(Last)	(First)	Y/N	/ /	M or F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
CHILDREN	1			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	2			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	3			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	
	4			/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No	

REFUSAL OF GROUP INSURANCE	
I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.	
Coverage Refused (Check All That Apply): <input type="checkbox"/> Basic Life <input type="checkbox"/> AD&D <input type="checkbox"/> Dependent Life <input type="checkbox"/> Voluntary Life	
<input type="checkbox"/> Short Term Disability <input type="checkbox"/> Long Term Disability <input type="checkbox"/> Voluntary LTD <input type="checkbox"/> Dental <input type="checkbox"/> Voluntary Dental	
<input type="checkbox"/> Vision	

FRAUD WARNING (Not Applicable in AZ, FL, GA, MD, OR, VA): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits (in TX, may be committing) a fraudulent insurance act, which is a crime and subjects (in KS, which may be determined by a court of law to be a crime which subjects) such person to criminal and civil penalties.

FRAUD WARNING (FL only): Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Date	Your Signature X
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NOTICE TO PROPOSED INSURED – DETACH AND GIVE TO PROPOSED INSURED

In connection with your application for insurance as part of our normal underwriting procedure, an investigative consumer report may be obtained, including, if applicable, information as to character, general reputation, personal characteristics and mode of living. This information is obtained through personal interviews with your friends, neighbors and associates. Upon written request, received within a reasonable time, additional, detailed information concerning the nature and scope of this investigation will be provided.