

EMPLOYEE ENROLLMENT FORM

F O R G R O U P C O V E R A G E



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Applying for: Basic Life and AD&D Yes No Optional Life Yes No Short Term Disability Yes No
Dependent Life Yes No Long Term Disability Yes No

Section A ó All ways complete this section.

Employee name _____ Social Security No. _____
Last First MI
Address _____ City _____ State _____ ZIP _____
Date of birth ____/____/____ Gender: Male Female Single Married Legally separated
M M D D Y Y Y Y
Spouse name _____ Social Security No. _____
Last First MI
Spouse date of birth ____/____/____ Gender: Male Female
M M D D Y Y Y Y
Employer HMS Enterprises, Inc. Girard, KS 00023006 Work phone () _____
Empl oyer's name City
Hourly wage \$ _____ Full-time employment date ____/____/____ Rehire date ____/____/____
M M D D Y Y Y Y M M D D Y Y Y Y
Occupation/job title _____ I work _____ hours each week for this employer.
I am actively at work performing all of my job duties. Yes No Does the firm shown above employ your spouse? Yes No
Do you have eligible dependent children under the age of 23? Yes No

Section B ó Beneficiary designation.

Primary beneficiary*
Last First MI Relationship Age Social Security No. _____
Last First MI Relationship Age Social Security No. _____
Contingent beneficiary**
Last First MI Relationship Age Social Security No. _____
Last First MI Relationship Age Social Security No. _____

* Primary beneficiary will receive the death benefit. If naming two or more beneficiaries, the proceeds will be paid in equal shares unless stated otherwise. If listing a minor child as a beneficiary, the proceeds will be paid to a legal representative appointed by the court system on behalf of the child. If applying for dependent life, it is not necessary to name a beneficiary.

** Contingent beneficiary will receive the death benefit **only** if the primary beneficiary is deceased.

Section C ó Employee signature and date always required.

I hereby request to be insured for the insurance coverage for which I may become eligible under the group policies in which my employer participates as issued by Advance Insurance Company of Kansas. I believe that all persons for whom I am requesting coverage are resident citizens of the U.S.A. or are aliens legally residing in the U.S.A., and that, to the best of my knowledge, the information which I have provided on this form is true and correct as it pertains to my status with the above employer.

I request the insurance provided by my participating employer's group insurance plan(s) and authorize the required payroll deduction (if any) from my wages.

I understand that if I am not at work on the effective date of my coverage, my insurance will not begin until the day I return to work. If I do not enroll when first eligible, I understand evidence of insurability may be required and that my coverage may be declined.

Employee sign here X Date signed _____

Section D ó Non-acceptance. Complete this section only if you DO NOT WISH TO ENROLL.

The group insurance program has been offered to me and after seriously considering its benefits, I have decided not to enroll:

Myself My spouse My dependent children in the program. Reason: _____

I understand that if I do not enroll when first eligible and choose to participate in the insurance program at some future date evidence of insurability may be required, perhaps to include passing a thorough physical by the applicant(s) at my own expense, and that coverage may be declined.

Employee sign here X Date signed _____

Employer sign here X _____