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|--|-------------------------|--|---------------------------|--|--|
| Name of Employee (Last Name, First Name, MI) | | | Social Security Number | | |
| Employee Address | | City | State | Zip Code | |
| Date of Birth (MM/DD/YY) | | Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced | | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Annual Salary | Number of Hours Worked* | Job Title | | Date of Hire (MM/DD/YY) | |
| Company Name | | Policy Number | Effective Date (MM/DD/YY) | Coverage Amount | |

* Employee must be actively performing the regular duties of their job for at least 20 hours per week in the usual manner and at the usual place of employment or business. If not working due to illness or injury, employee will **not** be eligible for coverage until they return to work.

| | | | |
|-------------------------|--------------|------------------------|--------------|
| Beneficiary of Employee | Relationship | Contingent Beneficiary | Relationship |
|-------------------------|--------------|------------------------|--------------|

If more than one beneficiary is designated, interest will be equal unless otherwise indicated.

Dependent Coverage: Please verify with Employer that you are applying for these benefits. If employed, spousal dependents must be actively performing the regular duties of their job week in the usual manner and at the usual place of employment or business. If not working due to illness or injury, Dependent will **not** be eligible for coverage until they have returned to work. If your Spouse is not employed, they must be able to perform the normal duties of a person of the same age and gender (if your Spouse or Dependent Child is disabled, they are **not** eligible for coverage).

Dependent Term Coverage: Yes No

If you answered "Yes" to Dependent Coverage, please list all dependents to be covered. Attach a list for additional dependents.

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|------|--------------|---------------|------|--------------|---------------|
| Name | Relationship | Date of Birth | Name | Relationship | Date of Birth |
|------|--------------|---------------|------|--------------|---------------|

I hereby apply for group insurance as indicated above and authorize my Employer to make the necessary deductions from my earnings to apply toward the premiums, if required. I understand that all insurance coverages will be effective according to the terms of the contract.

Date: _____ **Signature:** _____

Please Note: If applying for over \$50,000 of coverage, please complete the special Simplified Application for Group Term Life.