

EMPLOYEE'S GROUP APPLICATION
ASSURITY LIFE INSURANCE COMPANY – Lincoln, Nebraska

New Enrollee **Coverage Change**

Name of Employer: _____ Location: _____

Certificate No.

Group No.

A. Employee Information

Name: **Last:** _____ **First:** _____ **Middle:** _____

Male Female Date of Birth: ___ / ___ / ___ Age: _____ Soc. Sec. No: _____ - _____ - _____

Residence Address: _____ City: _____ State: _____ Zip: _____

Date of Employment: ___ / ___ / ___ Occupation: _____ Hrs. per week: _____ Annual Salary \$ _____

Are you now and have you been actively at work? Yes No Married Single Widowed Divorced

NOTE: There is an "actively at work" requirement for coverage to be in force. Employees not able to work or dependents not able to perform the normal activities for their age will not be insured until this requirement is satisfied.

Have you ever used any form of tobacco or nicotine, including nicotine substitutes (e.g. patches or gum)? Yes No

If YES, indicate date and type last used: Date: ___ / ___ / ___ Type: _____

Dependents to be insured: Spouse Only Children Only Spouse & Children None

Are any dependents now disabled? Yes No (Disabled dependents are not eligible until fully recovered)

If YES, Who? _____ Relationship to Employee: _____

B. Voluntary Benefit Election

Employee Life Amount: \$ _____ (Completion of a Statement of Health form may be required for coverage to be approved.)

Riders: (if available)

Accidental Death & Dismemberment: Yes No Amount: \$ _____

Spouse Coverage: Yes No Amount: \$ _____ Spouse Date of Birth ___ / ___ / ___

Child Coverage: Yes No

Critical Illness: Yes No Amount: \$ _____ or — _____ % of Life Amount

Supplemental A D & D: Yes No Amount: \$ _____ Employee Only Family

Special Requests: _____

C. Beneficiaries (Print in full. Use given names. Unless shown differently below, survivors share equally.)

Name (Please Print)	Relationship	P = Primary C = Contingent	Date of Birth	Soc. Sec. No.	Share %
_____	_____	_____	___ / ___ / ___	____ - ____ - ____	_____
_____	_____	_____	___ / ___ / ___	____ - ____ - ____	_____
_____	_____	_____	___ / ___ / ___	____ - ____ - ____	_____
_____	_____	_____	___ / ___ / ___	____ - ____ - ____	_____

Authorization and Acknowledgment

- All answers and statements made on this application are in writing, complete and true to the best of my knowledge and belief, and they will be the only information given by me that the company will rely on in issuing coverage.
- No insurance is in force until this application is accepted by the home office.
- The employer may make deductions from the employee's earnings in the amount of his or her share of premiums (including premiums for dependent's coverage).

Dated at: _____ City _____ State _____ On: _____ Month _____ Day _____ Year _____

Signature of Proposed Insured _____

TO BE COMPLETED BY ADMINISTRATOR

Class	Division	Section
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HOME OFFICE USE ONLY									
	Effective Date	Life	AD & D	Voluntary Life	Voluntary AD & D	Critical Illness	LTD	STD	Supp AD & D
Employee									
Spouse									
Children									