ENROLLMENT FORM
GROUP COVERAGE

☐ New Application
☐ Application for Change

2930 S.W. Woodside Dr., Suite A, Topeka, Kansas 66614-5326

Employee Name ______________________ (Last, First, M.I.) Sex ______ Birth Date ______________ (Mo. Day Yr.) SS # ______________

Spouse Name ______________________ (Last, First, M.I.) Sex ______ Birth Date ______________ (Mo. Day Yr.) SS # ______________

Address ______________________ City ______________ State ______ Zip Code ______________

Home Phone ______________ Business Phone ______________ Rehire Date ______________ (Mo. Day Yr.)

Employer ______________________ Full-Time Employment Date ______________ (Mo. Day Yr.)

Employee Occupation/JobTitle ______________________ Earnings $ ______________ ☐Hr.. ☐Wk.. ☐Yr. ☐Mo.

☐Single ☐Married Is spouse employed by above employer? ☐Yes ☐No

*Primary Beneficiary

Last	First	M.I.	SS#	Relationship	Age

**Contingent Beneficiary

Last	First	M.I.	SS#	Relationship	Age

* Primary Beneficiary will receive death benefit upon the death of the insured.
** Contingent Beneficiary will receive death benefit only if primary beneficiary is deceased.
BENEFICIARY: (If a minor child is listed as a beneficiary, proceeds will only be paid to the court appointed conservator of the child).

ARE YOU CURRENTLY WORKING FOR THIS EMPLOYER? ☐Yes ☐No How many hours do you work each week for this employer? ______________	Applying for: Dependent Life ☐Yes ☐No Short Term Disability ☐Yes ☐No Long Term Disability ☐Yes ☐No

(OFFICE USE ONLY)

CLASS	TERM	AD&D	OTHER	EFFECTIVE DATE	ACCOUNT NUMBER

Unless otherwise provided herein, if two or more Beneficiaries are named, the proceeds shall be paid in equal shares to the named Beneficiaries if surviving the Insured, or the Survivor or Survivors. If no Beneficiary survives, payment shall be made in accordance with the terms of the policy, subject to revocation by me by written notice to my Employer. I request the insurance provided from time to time by my employer's group insurance plan(s) and authorize the required deduction (if any) from my wages.

Employee Signature ______________________________ Date ______________ (Mo. Day Yr.)

SIGNATURE AND DATE ARE ALWAYS REQUIRED

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