

EMPLOYEE ENROLLMENT FORM – for Life, Disability, Dental and Vision

EMPLOYER INFORMATION						
Group Name					Group Number	
EMPLOYEE INFORMATION						
Name (last, first, middle)		Address (street, city, state, zip)			Residence Phone number () -	
Occupation	Class	Regular # Hours Worked per Week:	Income: \$ <input type="checkbox"/> Annual <input type="checkbox"/> Hourly	Date of Hire: Full-time: ___/___/___ Part-time: ___/___/___	<input type="checkbox"/> Single <input type="checkbox"/> Married	
INSURANCE COVERAGE (Verify coverages with your employer. Select coverage by checking Yes or Waive coverage by checking No to each applicable coverage.)						
Self	Life/AD&D <input type="checkbox"/> Yes <input type="checkbox"/> No	Supplemental Life <input type="checkbox"/> Yes \$ _____ <input type="checkbox"/> No	Dental <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	STD <input type="checkbox"/> Yes <input type="checkbox"/> No	LTD <input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent(s)	Dependent Life <input type="checkbox"/> Yes \$ _____ <input type="checkbox"/> No		Dependent Dental <input type="checkbox"/> Yes <input type="checkbox"/> No		Dependent Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	
If waiving coverage, please specify reason for waiving:						
PPO Network (if applicable):						
Beneficiary			Relationship		Beneficiary Social Security #	
GENERAL INFORMATION						
Full Name (First, middle, last) Employee listed above	Relationship	Birthdate (mo., day, year)	Sex M/F	Social Security Number	Student* or Disabled	Coverages (refer to coverages listed above)
	Self					
	Spouse					
	Child					
	Child					
	Child					
*If a student and over age 19, provide a current copy of full-time registration.						
Do any of the above listed have other coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Please specify person's name, name of carrier, and policy number of other coverage.						
ACKNOWLEDGMENT (SEE NOTIFICATION STATEMENTS ON THE REVERSE SIDE.)						
With my signature below, I confirm I have read and understand the New Entrant Notice and Fraud Statements printed on the reverse side. When this insurance becomes effective, I authorize deduction from my wages to pay my portion, if any, of the premium. I hereby state the statements are true and have been completed to the best of my knowledge and belief.						
Date: ___/___/___		Signature: _____			Home Office Use Only	

NEW ENTRANT NOTICE (Only applicable to Disability Coverage)

If you have received medical care or advice within the 90 days preceding your original effective date for an illness or physical condition, you may not be covered for that illness or physical condition for up to one year under this plan. This exclusion applies only to an illness or physical condition for which medical care or advice has been received within the 90 days preceding your original effective date. Please consult your certificate of coverage for specific information regarding the preexisting condition exclusion that applies to you. "New Entrant" is any individual who was not covered under this employer's previous plan(s) for the past 12 months.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF PENNSYLVANIA, DELAWARE, KENTUCKY AND OHIO

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

FRAUD STATEMENT APPLICABLE TO RESIDENTS OF VIRGINIA

Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

FRAUD STATEMENT APPLICABLE TO APPLICATIONS TAKEN IN THE STATE OF NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

EDUCATORS MUTUAL LIFE Insurance Company

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**EDUCATORS
MUTUAL LIFE**