



AMERICAN GENERAL

The United States Life Insurance Company in the City of New York
A member company of American International Group, Inc.

Group Employee Enrollment Form

Completing Your GROUP ENROLLMENT FORM

- Fully complete** each section
- Sign and date** Refusal/Authorization Section, as needed.

- NEW ENROLLMENT**
- CHANGE IN ENROLLMENT**

1. PERSONAL DATA: (Must always be completed)										
Group No.	Div. No.	Class	Social Security No.				Last Name		First Name	Initial
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth	MM	DD	YY	Street Address			City	State	Zip Code
Name of Employer					Location			Salary \$ Per _____		
Occupation			Title		Date of Full-Time Employment		MM	DD	YY	No. Hours Worked Per Week <input type="checkbox"/> Union <input type="checkbox"/> NonUnion
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				Dependent Children <input type="checkbox"/> No <input type="checkbox"/> Yes			If Yes, # _____			
2. ENROLLMENT										
If enrolling for Dental or Vision benefits, list name, relationship to you, and date of birth for each dependent to be insured. PLEASE LIST ADDITIONAL DEPENDENTS ON A SEPARATE SHEET. Give policy number, name and address of current employer's prior group insurance carrier, if you and your dependents were insured. Indicate your effective and termination dates of coverage also.										
Name	Relationship	Self	Sp.	Ch.	Date of Birth	MM/DD/YY	Sex			
SELF		X								
3. Supplemental Life Benefit: If this benefit is a plan option and you wish to enroll for Supplemental Life coverage, please indicate										
The amount \$ _____										
4. Beneficiary Designation: as is										
EX: MARY A. JONES, WIFE		First Name		Initial		Last Name		Relationship		
NOT MRS. JOHN JONES										
5. REFUSAL OF COVERAGE: (Note: Benefits provided on a non-contributory basis cannot be refused)										
I was given the opportunity to enroll in this plan for group insurance offered by my employer/association and insured by UNITED STATES LIFE.										
I am refusing:			Dental:			Vision:				
<input type="checkbox"/> LTD	<input type="checkbox"/> STD	<input type="checkbox"/> Life/AD&D	<input type="checkbox"/> Dependent Life	<input type="checkbox"/> Supplemental Life/AD&D	<input type="checkbox"/> All coverages offered	<input type="checkbox"/> Employee & Dependents	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> All Dependents	
<input type="checkbox"/> Employee & Dependents	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> All Dependents	<input type="checkbox"/> Employee & Dependents	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> All Dependents			
MUST ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD COVERAGE:										
Are you or your dependents now covered by any other group plan? <input type="checkbox"/> YES <input type="checkbox"/> NO (Your dependent(s) may be insured by this Plan even if they are insured elsewhere)										
If Yes: Policyholder's Name _____ Carrier _____										
I understand that if I am refusing insurance because I am insured under another applicable insurance plan, I may be added to this plan under the same terms and conditions with respect to pre-existing conditions and their limitations as if I enrolled when initially eligible. I understand that I must request enrollment within 31 days following the termination of other other applicable insurance plan.										
If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage.										
I must furnish, at my expense, evidence of insurability satisfactory to United States Life if I later wish to enroll in any other coverage that is now being refused.										
_____ DATE OF REFUSAL					_____ SIGNATURE IF REFUSING ANY COVERAGE					
IF REFUSING ALL COVERAGES, IT IS NOT NECESSARY TO COMPLETE THE REMAINDER OF THIS FORM.										
6. AUTHORIZATION:										
<ul style="list-style-type: none"> I hereby certify that all information furnished is true to the best of my knowledge. I request group insurance for which I am or may become eligible. If I am required to contribute to the premium for any coverage elected on this form, I hereby authorize my employer to deduct such contributions in advance from wages due me, for remittance to The United States Life Insurance Company in the City of New York. 					<ul style="list-style-type: none"> I designate the beneficiary named on this form to receive the proceeds, if any, payable upon my death. If dental care or health care is provided by a participating provider, all benefits will be paid directly to the provider by United States Life. I authorize any insurer or employer or any consumer reporting agency acting on its behalf to give to United States Life information about me. Such information will pertain to my employment or other insurance coverage. 					
_____ DATE SIGNED					_____ APPLICANT'S SIGNATURE					

Terms of eSignature:

Providing your Name, Social Security Number and checking the box below is the same as providing your signature on a hard copy document. By checking the box below you certify that:

- The information provided in the Application is true, accurate and complete.***
- You have read, or have had read to you, the completed Application and understand that any false statement or misrepresentation made in it may result in a loss of coverage.***

● I have read and agreed to the terms of eSignature

In order to “SUBMIT” you must read and agree to the terms of eSignature