Administered by:
Plan Administration, Ltd.

Voluntary Enrollment Application

Return To: Plan Administration Ltd
580 Hazard Avenue
Enfield, CT. 06082

Please print or type all information. Complete and sign at the bottom.

EMPLOYEE Name-LAST	FIRST	MIDDLE INITIAL	Social Security No.	Group Number	Division	Class

Home Address	City	State	ZIP	Sex	Date of Birth(MM/DD/YY)	Marital Status
				☐ MALE ☐ FEMALE		

Occupation	Employer Name	Hire Date(MM/DD/YY)	Hours Worked per week	Annual Salary

Primary Beneficiary (For Employee Life)	Social Security #	Relationship	Date of Birth(MM/DD/YY)

Contingent Beneficiary	Social Security #	Relationship	Date of Birth(MM/DD/YY)

Employee Coverage Amt: Life/AD&D ☐ _____ STD ☐ _____ LTD ☐ _____ Critical Illness ☐ _____

Spouse Coverage Amt: $ _____ Dependent Coverage Amt: $ _____

If applying for Spouse/Dependent Coverage, complete section below

Name (Last, First, MI)	Social Security #	Date of Birth(MM/DD/YY)	Sex (M / F)
Spouse			
Child(ren)			

If dependent children are full-time students in college, vocational or trade school or graduate school please complete the following:

Child(ren)	Name of School	# or Hours

To decline coverage, complete this section. ☐ **Employee** ☐ **Spouse/Dependent**

I understand that I have been given an opportunity to participate in the group insurance plan offered by my employer I am refusing the term life insurance coverage indicated above for which I am required to contribute. If I and/or my dependents wish to participate at a later date, I understand that coverage(s) may be limited and satisfactory evidence of insurability may be required.

Reason for refusing coverage: _____

Employee's signature: _____ **Date:** _____

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under group policy(ies) issued to the employer listed above. I understand that if I am not actively at work as defined in the policy on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition actively at work.

Any person who knowingly and with 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 may subject such person to criminal or civil penalties.

Employee's signature: _____ **Date:** _____

Read eSignature Terms

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

Click to Submit