

Enrollment Application

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

Please print or type all information.

Complete and sign at the bottom.



AMERICAN
GENERAL

The United States Life Insurance
Company In the City of New York
Member of American International Group, Inc.

Employee Name (Last, First, Middle)		Social Security Number	Group Number	Division	Class
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Your Home Address	City	State	ZIP	Sex (M/F)	Date of Birth	Marital Status
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Your Occupation	Employer Name	Hire Date	Hours Worked Per Week	Annual Salary
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Primary Beneficiary (For Life and AD&D)	Relationship	Date of Birth
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Contingent Beneficiary	Relationship	Date of Birth
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Life Coverage Requested:

Circle Employee Coverage desired

Coverage Amount	Monthly Rates
\$ 20,000	\$ 3.60
\$ 30,000	\$ 5.40
\$ 40,000	\$ 7.20
\$ 50,000	\$ 9.00
\$ 60,000	\$ 10.80
\$ 70,000	\$ 12.60
\$ 80,000	\$ 14.40
\$ 90,000	\$ 16.20
\$ 100,000	\$ 18.00

Spouse/Dependent Coverage
\$10,000/\$10,000 \$ 3.16

AD&D Coverage Requested:

Employee \$.02/\$1,000 benefit

Spouse \$.02/\$1,000 benefit

If applying for Spouse/Dependent Coverage, complete section below:

Name (Last, First, MI)	Social Security Number	Date of Birth	Sex (M/F)
Spouse			
Child(ren)			

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

Child(ren)	Name of School	# of Hours

To decline coverage, complete this section.

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

Reason for refusing coverage: _____

Employee's Signature: _____ Date: _____

I hereby apply for coverage as indicated above and authorize my employer to deduct from my earnings any required contributions.

I understand if I am not actively at work on the date coverage would otherwise take effect that my coverage will be delayed until I return to full-time, active work. I also understand that coverage on a spouse or dependent child who is unable to engage in most of the normal activities of a person in good health and of the same age and sex on the date coverage would otherwise take effect will be delayed until he or she is no longer disabled. I understand that any misstatement on this enrollment application may result in a denial of a claim and/or discontinuance of coverage.

Employee's Signature: _____ Date: _____