PLAN ADMINISTRATION, LTD
GROUP ENROLLMENT CARD

Group Policy No.	Cert No.	Social Security (Cert) No.

APPLICANTS Last Name (Please Print)	First Name	Initial	State	Class	SEX M F

APPLICANTS RESIDENCE	Street Address	City	State	Zip

Name of Employer, Association or Union	Location

Salary $ Hrs. Worked	Union Non-Union	Date of Birth Mo.	Day	Year	Occupation	Title

Date Employed Full Time Mo.	Day	Year	Date Eligible Mo.	Day	Year	Life & AD&D

Other Spouse Benefits	A&S	LTD	Dependent	Sup\Vol

BENEFICIARY DESIGNATION (Please Print)	First Name	Initial	Last Name	Relationship

I (1) REQUEST THE GROUP INSURANCE COVERAGE FOR WHICH I AM OR MAY BECOME ELIGIBLE (2) AUTHORIZE DEDUCTIONS FROM MY PAY OR DUES FOR MY SHARE OF THE COST, IF ANY, AND (3) DESIGNATE THE BENEFICIARY NAMED ON THIS CARD TO RECEIVE THE PROCEEDS; IF ANY, PAYABLE IF I DIE.

REV. 1/1/95

_____ Date Signed

X _____ Applicants Signature

RECORD OF CHANGES

Date Effective Mo	Day	Year	Increase/Decrease	Date Processed Mo	Day	Year

PLAN ADMINISTRATION, LTD