

<b>PLAN ADMINISTRATION, LTD</b> Group Enrollment Card		<b>Social Security #</b>	<b>Pal #</b>	<b>Cert#</b>
<b>Name of Employer, Association or Union</b>				
<b>EMPLOYEE'S NAME</b> (Please Print)		<b>Last</b>	<b>First</b>	<b>Initial</b>
		<b>Sex</b> M    F		<b>Class</b>
<b>EMPLOYEE'S RESIDENCE</b>				
<b>Salary \$</b> <b>Hrs worked</b>	<b>Union Non-Union</b>	<b>Date of Birth</b>	<b>Date Employed(Full Time)</b>	<b>Effective Date</b>
<b>Occupation</b>	<b>Other Benefits (Circle One) Type of Coverage</b>			
	<b>Dental/Vision Employee</b>	<b>Employee/Child</b>	<b>Employee/Spouse</b>	<b>Full Family</b>
<b>Benefit Type</b> (Check all that Applies)	<b>Life &amp; AD&amp;D</b> <input type="checkbox"/>	<b>STD</b> <input type="checkbox"/>	<b>LTD</b> <input type="checkbox"/>	<b>Dep</b> <input type="checkbox"/>
	<b>Other (Please Specify)</b> <input type="checkbox"/>	_____		
<b>BENEFICIARY DESIGNATION</b> (Please Print)	<b>First Name</b>	<b>Initial</b>	<b>Last Name</b>	<b>Relationship</b>
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.				
<b>Date</b> _____	<b>Employee's Signature</b> _____			