Enrollment Form

For group coverage – life only

www.advanceinsurance.com

Section 1

INSTRUCTIONS: Please PRINT in CAPITAL letters using **black ink** only.

Name ______________________ (Last (Sr., Jr., etc.) / First / MI)

Date of Birth ______ (MM / DD / YYYY)

Address ______________________ (Street)

______________________ (City / State / ZIP Code)

Social Security No. ______

Gender ☐ Male ☐ Female   Married? ☐ Yes ☐ No

Home Phone ______ (Area Code)   Work Phone ______ (Area Code)   Date of Marriage ______ (MM / DD / YYYY)

Employed by ______________________   Group No. ______

Actively working ____ hrs weekly for this employer   Date of Hire ______ (MM / DD / YYYY)

Reason for change in employment: ☐ part time to full time ☐ temporary to permanent ☐ rehire/recall ☐ other (specify)

Date this occurred ______ (MM / DD / YYYY)

Section 2

Employee Occupation/Job Title		Earnings $ ______ ☐ HR ☐ WK ☐ MO ☐ ANN	Eligible dependent children under 23? ☐ Yes ☐ No
Are you currently working for this employer? ☐ Yes ☐ No	Does your spouse work for this employer? ☐ Yes ☐ No	Enrolling in: Dependent Life ☐ Yes ☐ No; Short Term Disability ☐ Yes ☐ No	Long Term Disability ☐ Yes ☐ No

	Last / First / M.I.	Address	Relationship	Age
Primary Beneficiary	1			
	2			
Contingent Beneficiary	1			
	2			

If this space is inadequate for your beneficiary(ies), attach a separate signed and dated list providing complete information.

Section 3

Beneficiary Tips

- A primary beneficiary will receive death proceeds upon the death of the insured.
- A contingent beneficiary will receive death proceeds only if primary beneficiary(ies) are deceased.
- If a minor is listed as a beneficiary, proceeds will be paid to a conservator appointed by the court system on behalf of the child.
- Employees with living trusts or estate planning vehicles should contact their legal or tax counsel to choose the beneficiary designation wording best suited to their needs.
- If two or more Beneficiaries are named, the proceeds shall be paid in equal shares unless you instruct us otherwise in writing.
- The form must be signed and dated to be valid.

I understand that if I am not at work on the effective date of my coverage, my insurance will not begin until the day I return to work. If I do not enroll when first eligible, I understand evidence of insurability will be required, that I will be responsible for any fees or cost associated with the physical or for obtaining medical records as a late enrollee and that coverage may be declined.

Your signature required ______________________ **Date** ______

*An Independent Licensee of the Blue Cross and Blue Shield Association.

WAIVER OF COVERAGE FORM

DECLINING GROUP COVERAGE

1133 S.W. Topeka Boulevard, Topeka, KS 66629-0001
Phone in Topeka (785)273-9804, in Kansas (800)530-5989
Fax (785)290-0727 website: www.advanceinsurance.com

I DO NOT WANT TO ENROLL IN:

(Note: unless you are paying some (or all) of the premium for the benefit named below, declining coverage is not an option available to you.)

- Basic Life and AD&D ☐
- Dependent Life ☐
- Short Term Disability ☐
- Long Term Disability ☐
- Optional Life ☐
- Voluntary Life (and AD&D, if applicable) ☐
- Voluntary Short Term Disability ☐
- Voluntary Long Term Disability ☐
- Voluntary AD&D ☐

The group insurance program has been offered to me and, after seriously considering its benefits, I have decided not to enroll.

Reason: ______________________________

I understand that satisfactory Evidence of Insurability will be required if I, my spouse, or children do not enroll when first eligible and choose to participate in the insurance program at some future date. I understand I will be responsible for payment of all expenses necessary to determine a Late Enrollee's insurability, including but not limited to, exams or obtaining medical records for myself (my spouse, or children); and, that the late enrollee may be declined for the insurance.

Employee name (please print) ______________________ **Social Security #** ____________

Employee sign here X ______________________ **Date signed** ____________

Employer name ______________________ Location ____________

Employer sign here X ______________________ Group # ____________

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