

MEDICAL LIFE INSURANCE COMPANY

ENROLLMENT FORM (Please Print)

___ New Enrollment Change

Employer: If group is self-administered, submit enrollment form **only** if evidence of insurability is required. If group is not self-administered, submit enrollment form to us.

EMPLOYEE NAME – LAST	FIRST	MIDDLE INITIAL	SEX M F	DATE OF BIRTH	DATE OF HIRE (FULL TIME)
SOCIAL SECURITY NO. (THIS IS YOUR CERTIFICATE NO.)	EARNINGS \$ _____ Monthly Weekly Annual		JOB TITLE		CLASS
EMPLOYER		GROUP NO. /ACCOUNT NO.		LOCATION	

COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.

Basic Coverage(s):			
Basic Life/AD&D <input type="checkbox"/> YES <input type="checkbox"/> NO	STD Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO	LTD Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO	Dependent Life <input type="checkbox"/> YES <input type="checkbox"/> NO

Supplemental Life Add Change Cancel \$ _____	Supplemental AD&D Add Change Cancel \$ _____	Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No \$ _____
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BENEFICIARY DESIGNATION (For Employee Only: Must Be Completed if you have applied for life or AD&D insurance) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100% (Employee is the beneficiary of proceeds from spouse or child coverage.)

FIRST NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY #	BENEFIT %
Primary					%
Primary					%
Contingent					%
Contingent					%

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 THE GROUP POLICY(IES) ISSUED TO THE EMPLOYER LISTED ABOVE. I UNDERSTAND THAT IF I AM NOT ACTIVELY AT WORK ON THE EFFECTIVE DATE OF MY COVERAGE, MY INSURANCE WILL NOT BEGIN UNTIL THE DAY I RETURN TO WORK. FOR THOSE COVERAGES I HAVE DECLINED, I UNDERSTAND THAT IF I CHOOSE TO ENROLL AT A LATER DATE, MY COST MAY BE HIGHER AND A HEALTH QUESTIONNAIRE MAY BE REQUIRED.

As Arizona is a community property state, it may be necessary to obtain your spouse's signature, if you are naming someone other than you spouse as beneficiary. *

WARNING: Any person who, with intent to defraud or knowing that his facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud. (ORC Section 3999.21) (not enforceable in OR or VA)

EMPLOYEE SIGNATURE _____ DATE ____/____/____

FOR MLI USE ONLY
