ASSURITY® LIFE INSURANCE COMPANY
Post Office Box 82533, Lincoln, NE 68501-2533
(402) 476-6500 • (866) 289-7337 • www.assurity.com

EMPLOYEE GROUP ENROLLMENT FORM

PLEASE PRINT WITH BLACK INK

☐ New Enrollee ☐ Coverage Change Name of Employer________________ Location________________

A. Employee Information

Employee's Legal Name *First, Middle, Last*	Date of Birth *(MM/DD/YYYY)* / /
Employee's Home Address *Street Address* *City* *State* *ZIP+4*	Personal Phone No. ( )
☐ Male ☐ Female · Social Security No.	Height ft. in. · Weight lbs.
Date of Employment *(MM/DD/YYYY)* / / · Hours per week	Annual Salary $

Are you now and have you been actively at work? ☐ Yes ☐ No If NO, please explain ________________

During the past **12 months**, has any Proposed Insured used any form of tobacco or nicotine-based products or substitutes such as patches or gum?
Employee .... ☐ Yes ☐ No
Spouse .... ☐ Yes ☐ No

Spouse's Legal Name *First, Middle, Last*	Date of Birth *(MM/DD/YYYY)* / /
☐ Male ☐ Female · Social Security No.	Height ft. in. · Weight lbs.

CHILD INFORMATION: If additional space is needed, please attach a separate sheet of paper.

Child's Legal Name *First, Middle, Last*		Date of Birth *(MM/DD/YYYY)*
Child's Legal Name	☐ Male ☐ Female	Date of Birth / /
Child's Legal Name	☐ Male ☐ Female	Date of Birth / /
Child's Legal Name	☐ Male ☐ Female	Date of Birth / /
Child's Legal Name	☐ Male ☐ Female	Date of Birth / /

B. Voluntary Benefit Election — Completion of a Statement of Health form may be required for coverage to be approved.

Note: Coverage not elected will be considered refused even if not specifically declined.

Accident Expense ☐ Yes ☐ No ☐ Plan A ☐ Plan B ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child ☐ Family

Disability Income ☐ Yes ☐ No Benefit $________ ☐ Plan A ☐ Plan B

Critical Illness ☐ Yes ☐ No ☐ Plan A ☐ Plan B ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child ☐ Family

C. Beneficiaries — Unless shown differently below, survivors share equally. If additional space is needed, attach a separate sheet of paper.

Legal Name *(First, Middle, Last)*	Relationship	P=Primary C=Contingent	Date of Birth	Social Security No.	Share %
			/ /		
			/ /		

D. Certification and Authorization

I certify that the statements and answers provided in this application were made by me, are complete and true, and have been correctly and fully recorded. I agree that this enrollment form constitutes my application and shall form a part of the certificate if attached thereto. My statements and answers are offered as an inducement to grant insurance, and I understand that Assurity may use misstatements or misrepresentations in the application to contest the validity of any coverage provided. I further understand that the insurance applied for shall be in force as of the certificate issue date shown on the certificate schedule and not the date the application is signed. I understand that any premiums deducted before the issue date of the certificate are pre-paid premiums and will be applied to coverage beginning on the issue date. If the certificate is not issued, Assurity will refund any premium deductions it receives. I further authorize my employer to deduct from my salary or wages the necessary premium for the coverage(s) requested *(including dependents' coverage)*.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subject to a substantial civil penalty where and to the extent allowed by state law.

Signed at *(city, state)* ________________ Dated ____/____/____ *(MM/DD/YYYY)*

Signature of Primary Proposed Insured ________________________