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.	Birth State/Country
Date of Employment *(MM/DD/YYYY)* / /	Hours per week	Annual Salary $

In the past **90 days**, have you been working less than 30 hours per week or unable to perform any of the duties of your primary occupation? .... ☐ Yes ☐ No

If YES, 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.	Birth State/Country

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

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

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

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

Hospital Indemnity ☐ 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 presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

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

Signature of Primary Proposed Insured ____________________