To be Completed by Employer

Employer's Name

Enrolee Number

Date Enrolee Hired (full-time)

Weekly Income

Job Title

Certificate Number

$_________ $_________

Enrollee Life AD&D

**Coverage Information** (Check):

Sex: Male Female

Marital Status: Single Divorced

Married; Date married _________ (mo/dy/yr)

Are you applying for dependent coverage? Yes No

# Gerber Life Insurance Company, White Plains, NY

# Enrollment Card

1) *Enrollee Information section must be filled in,* whether or not you wish to accept the insurance coverage.
2) If you *do wish* to accept coverage, complete entire Form and sign the Acceptance statement.
3) If you *do not wish* to accept coverage, complete Enrollee Section only and sign DECLINE statement.
4) To *change your present plan,* check the change to be made, fill in your name. Enter the change in BENEFICIARY or COVERAGE section.

**Enrollee Information**

(Check): __New Enrollee __Coverage Change ___ Beneficiary Change

Name ______________________________ Birth Date ________
(Last) (First) (Middle Initial) (mo/dy/yr)

Address ______________________________ Apt # _____
(Number, Street or Post Office Box)

City ____________________ State __________ Zip ___________

Social Security # ____________________ Birthplace _____________

**Life Insurance Beneficiary** (*Fill in full name)*

(Primary Beneficiary)

Name ______________________________ Relationship _________
(Last) (First) (Middle Initial)

(Contingent Beneficiary)

Name ______________________________ Relationship _________
(Last) (First) (Middle Initial)

I hereby make the following beneficiary designation with respect to all the Insurance on my life under this Group Life Insurance Plan and, if I am already covered under the Plan, I hereby revoke my prior beneficiary designation.

**Dependent Information** *(Complete only if applying for dependent coverage)*

____________________ Birth Date ________ ____________________ Birth Date ________
Spouse's Name (mo/dy/yr) Child's Name (mo/dy/yr)

____________________ Birth Date ________ ____________________ Birth Date ________
Child's Name (mo/dy/yr) Child's Name (mo/dy/yr)

____________________ Birth Date ________ ____________________ Birth Date ________
Child's Name (mo/dy/yr) Child's Name (mo/dy/yr)

**To Accept Coverage:**

(*Please read and sign this section)*

I request coverage under the group plan issued by Gerber Life Insurance Company, and I authorize my employer to deduct any required contribution for the insurance coverage from earnings.

I certify that I am employed by the employer named in this form, and that all other information stated above is correct.

I understand that coverage will become effective on the date approved by Gerber Life provided I am actively at work on the date of approval, and the initial contribution is paid. I also understand that dependents must be performing the normal activities of a person in good health of like age on the date of approval.

If I am not actively at work on the date that coverage would otherwise become effective, I will not become insured until the date I am actively provided such day is within three months of the date insurance would have taken effect; any dependents who are not performing their normal activities on the date coverage would otherwise become effective will not become insured until such date as he/she is performing those activities provided such day is within three months of the date insurance would have taken effect.

X__________________________ Date_______________
(Enrolee Signature)

**To Decline Coverage:**

*(Be sure you have completed the Enrolee Information section. Then, please read and sign this statement.)*

Although I have been given the opportunity to apply for this group insurance offered to me through my employer, I have decided not to participate in the program described above.

I understand that if I desire coverage after the initial enrollment date that coverage will be subject to approval of an insurability and health statement.

X__________________________ Date_______________
(Enrolee Signature)