P.O. Box 7725, San Francisco, CA 94120
1-888-646-0789

ENROLLMENT FORM FOR GROUP LIFE INSURANCE FOR CAREAMERICA LIFE INSURANCE COMPANY (CAREAMERICA LIFE)

NOTE: Please complete the entire enrollment form and return it to your employer. This form cannot be processed if information is incomplete.

GROUP NAME	GROUP POLICY NO.	SECTION NUMBER

SECTION 1 – APPLICANT

FIRST NAME	M.I.	LAST NAME	
ADDRESS	CITY	STATE	ZIP
GENDER ☐ MALE ☐ FEMALE	BIRTHDATE	SOCIAL SECURITY NO.	MARITAL STATUS ☐ SINGLE ☐ MARRIED

FULL TIME EMPLOYMENT DATE	AVERAGE HOURS WORKED PER WEEK	REHIRE DATE	CLASS/OCCUPATION	EARNINGS $ ________ (EXCLUDING OVERTIME, BONUSES, ETC.) ☐ HOUR ☐ WEEK ☐ MONTH ☐ YEAR

SECTION 2 – BENEFICIARY

Primary Beneficiary – CareAmerica Life will pay the proceeds to the primary beneficiary. If more than one person is named as primary beneficiary, the proceeds will be distributed equally to those who survive the insured, unless otherwise specified in the % column.

FIRST NAME	MI	LAST	SOCIAL SECURITY NUMBER	RELATIONSHIP	% OF BENEFITS	D.O.B.

STREET ADDRESS	CITY	STATE	ZIP

FIRST NAME	MI	LAST	SOCIAL SECURITY NUMBER	RELATIONSHIP	% OF BENEFITS	D.O.B.

STREET ADDRESS	CITY	STATE	ZIP

Contingent Beneficiary – Proceeds will be paid to a contingent beneficiary only if no primary beneficiary survives the insured.

FIRST NAME	MI	LAST	SOCIAL SECURITY NUMBER	RELATIONSHIP	% OF BENEFITS	D.O.B.

STREET ADDRESS	CITY	STATE	ZIP

SECTION 3 – COVERAGE (COMPLETE ONLY TO APPLY FOR GROUP LIFE INSURANCE COVERAGE)

Please contact your employer's or association's administrative office to clarify coverages available. Coverage granted shall be subject to all provisions and limitations stated in the CareAmerica Life Insurance Policy. Evidence of Insurability must be submitted for amounts exceeding non-medical maximum limits or when enrolling outside of the initial eligibility period.

APPLICANT: ☐ **BASIC LIFE** ☐ **AD&D** ☐ SUPPLEMENTAL LIFE (& SUPPLEMENTAL AD&D IF WITHIN GROUP INSURANCE POLICY)
AMOUNT OF COVERAGE REQUESTED: $

DEPENDENT(S): ☐ BASIC DEPENDENT LIFE
NUMBER OF ELIGIBLE DEPENDENTS:
☐ SUPPLEMENTAL DEPENDENT LIFE
AMOUNT OF COVERAGE REQUESTED FOR SPOUSE: $ ________ CHILD(REN): $ ________

I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. I reserve the right to revoke this deduction at any time on written notice.

Sign Here to Apply for Coverage ________________________ Date Applicant Signed ____________

SECTION 4 – WAIVER OF COVERAGE (COMPLETE ONLY TO WAIVE GROUP LIFE INSURANCE COVERAGE)

The group program has been offered to me and after seriously considering it's benefits, I have decided:

(Please indicate your choice) ☐ (A) not to enroll myself or dependents ☐ (B) not to enroll my dependents

I understand that if I desire to participate in the program at some future date, my coverage or my dependent's coverage will not be effective until after Evidence of Insurability is submitted and approved. I understand that if a physical examination or other further medical information is required, it will be at my own expense.

Sign Here to Waive Coverage ________________________ Date Coverage Waived ____________

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