

**Group Employee
Application Form**



Policy # _____
 Account # _____
 Change _____
 OCC Class _____
 Late Entrant [] Yes [] No

Effective Date _____ New Employee [] Yes [] No

Employee: Last Name, First Name, Initial (Leave a space between each) _____ Social Security Number _____

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Mailing Address _____ City _____ State _____ Zip Code _____

Home Phone Number	Birthdate	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	<input type="checkbox"/> Male <input type="checkbox"/> Female
Name of Employer		Employer Phone Number	Location
Occupation		<input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker	Benefit Class
Full Time Date of Hire	Hours Worked Per Week	Rehire Date	Retired <input type="checkbox"/> Yes <input type="checkbox"/> No
Base Earnings \$ _____ <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Bi-Weekly <input type="checkbox"/> Weekly <input type="checkbox"/> Hourly		Average Annual Bonus/Commissions (if applicable) \$ _____	

COMPLETE FOR ALL FAMILY MEMBERS TO BE ENROLLED

	Last Name	First	Initial	Gender M/F	Birthdate	SSN
Spouse <input type="checkbox"/> Smoker <input type="checkbox"/> Non-Smoker						
Child; Full-Time Student? * <input type="checkbox"/> Yes <input type="checkbox"/> No						
Child; Full-Time Student? * <input type="checkbox"/> Yes <input type="checkbox"/> No						
Child; Full-Time Student? * <input type="checkbox"/> Yes <input type="checkbox"/> No						

* Proof of full-time student status for children older than 19 required at time of enrollment (not applicable in FL, TN, and TX); in LA, provide proof for children older than 21 at time of enrollment.

Please mark X in box before the coverages you are applying for if you are eligible for them under your employer's plan. Employee must be enrolled to cover spouse and dependent children. Maximum limits may apply to all coverages. Contributory or voluntary coverages not specifically elected will not be made effective, even if not refused.

COMPLETE FOR LIFE AND/OR DISABILITY COVERAGE

[] Basic Life	[] Supplemental Life	\$ _____	[] AD&D
	[] Voluntary Life _____ times Annual Earnings OR	\$ _____	[] AD&D
[] Basic AD&D	[] Voluntary Spouse Life _____% of Employee's Coverage OR	\$ _____	[] AD&D
[] Basic Dependent Life	[] Voluntary Dependent Children Life	\$ _____	
[] Basic STD	[] Voluntary STD		
[] Basic LTD	[] Voluntary LTD		

Are you actively at work? [] Yes [] No
 Are any of your dependents confined as an inpatient in a medical care facility? [] Yes [] No

If Yes, list name and relationship: _____

COMPLETE FOR DENTAL COVERAGE

Check all that apply:

Employee Spouse Children Number of Children _____

For multiple plan offerings, check one:

High Plan Low Plan Other Plan

Are you or your dependents covered under another dental insurance plan? Yes No

If Yes, list carrier name and policy number: _____

Does any individual proposed for coverage currently have continued coverage under Cobra? Yes No

COMPLETE FOR LIFE COVERAGE (EMPLOYEE ONLY)

BENEFICIARY	Last Name	First	Initial	Relationship	%
Primary					
Primary					
Contingent					
Contingent					

Unless otherwise indicated above, if more than one beneficiary is named, the share of any beneficiary who predeceases me shall be distributed equally among the surviving beneficiaries or beneficiary, if any; otherwise as provided in the Group Policy. I understand that if two or more beneficiaries are named, the words "in equal shares, survivors or survivor" shall be in effect as if written into the designation, unless other instructions are given over my signature.

EMPLOYEE DECLARATIONS

I hereby apply for group insurance for which I am eligible or may become eligible. I certify that all the information given is true and complete to the best of my knowledge and belief. I understand that I must be a U.S. citizen or permanent resident. I understand that the insurance I have selected for myself will begin on the effective date provided I am actively at work and not disabled on that date. Further, if my spouse or dependent children for whom coverage is applied is confined as an inpatient in a medical care facility on the date of my signature below and the effective date, that individual's effective date of coverage will be delayed until the day following such spouse's or dependent child's discharge from the medical care facility.

I further understand that if I have not elected the maximum benefits for which I or my spouse and/or dependent children are eligible, Shenandoah Life may require submission of evidence of good health satisfactory to Shenandoah Life to increase those benefits after the individual's initial period for enrollment has expired.

Any person who knowingly and with intent to defraud any insurance company or other persons, files an application for insurance or statement of claim containing any materially false information, or conceals information for the purpose of misleading, concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature _____ Date _____

