

1975 Tamarack Road P.O. Box 1009 Newark, OH 43058-1009 (800) 423-3151 WARNING: Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements is guilty of insurance or health care fraud under state and/or federal law.

New Application Only Coverages Elected					

EMPLOYEE APPLICATION - LARGE GROUP ONLY (50+ COVERED MEDICAL LIVES)

READ CAREFULLY AND COMPLETE IN INK TO PREVENT YOUR COVERAGE FROM BEING DELAYED. COMPLETE ALL SECTIONS OF THE APPLICATION. SIGN AND DATE THE AGREEMENT AND AUTHORIZATION. IF YOU WANT LIFE ONLY COVERAGE, YOU MUST COMPLETE THE ENTIRE APPLICATION. IF YOU ARE APPLYING FOR SPOUSAL COVERAGE, HAVE YOUR SPOUSE SIGN AND DATE THE AGREEMENT AND AUTHORIZATION. Employee Information (Please print in ink): Social Security Number Name ____ Home Address Telephone () **Employee Date of Birth** Sex Male **Marital Status** Who Is to Be Insured Date Hired ☐ Female ☐ Married ☐ Life Only Coverage Mo. Day Yr. Mo. Day Yr. ☐ Divorced ☐ Employee Only Widowed Employee and Spouse Height **COBRA Election Date** Earnings \$ ☐ Single Employee and Children ___/__/ Mo. Day Yr Yearly Weekly ☐ Common Employee, Spouse & Weight Law* Children ■ Monthly Employed by______Company Name City, State of Employment Group/Account Number Hours Worked Weekly _____ Occupation Relationship Beneficiary Name _____ * Complete Supplemental Information - Common Law Relationship **EMPLOYEE LIFE ONLY COVERAGE – WAIVER OF COVERAGE** All eligible employees must enroll for Life and AD&D, and if included in the employer's plan, Disability coverage. If you are declining enrollment for yourself or your dependents (including your spouse) because you have other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, placement for adoption, or your appointment as a legal guardian, you may be able to enroll yourself and/or your dependents, provided that you request enrollment within 30 days after the date of the marriage or appointment of legal guardianship, or 31 days of a birth, adoption, or placement for adoption. This plan will also allow enrollments as necessary to comply with the terms of medical child support orders, or qualified medical child support orders, as defined in applicable state or federal law. Other than as described above, please see the schedule of benefits for any additional waiting period, beginning with the date of late enrollment. I hereby waive ALL coverages except employee only group term life insurance. (Employee signature required on reverse.) I hereby waive THE FOLLOWING coverages. (Check all that apply. Employee signature required on reverse.) ☐ All Dental Coverage All Dependent Medical Coverage ☐ All Dependent Vision Coverage ■ All Vision Coverage ☐ All Dependent Dental Coverage Other _____ Ø **COMPLETE FOR DEPENDENT COVERAGE, including SPOUSE** Dependent coverage is not available for AD&D or Disability Insurance. If you do not wish to cover your eligible dependents, please complete the Waiver of Coverage section above. Date of Birth Height/ Weight S.S. Number Spouse Name Male or Female Spouse employed? Yes No If "Yes", employed by Date of Marriage: Policy Number: _____

Dependent Children:	1	.		T =		1	nship (Che		1	
Full Name	Date of Birth	Height/ Weight	Male or Female	Full-Time Student? (Y/N)	You and/or your spouse provide over 50% support		Adopted Child*	Step- Child	Custody or Guardian-ship	
Please attach to this applica	tion copies of the co	urt orders or lea	 al docume	nts creating this	relationship.					
Children insured elsewh		_		_		Policy	Numbe	r:		
Are any of the other De										
If yes, please complete			logal oat	olody of gual	alarioriip or ai	011101 1 0		1 100 (
Dependent	Person with L	egal Custody	Re	elationship to De	ependent	Ad	Address of Custodian			
If you are not the parent	t of any child list	ed above, do	es each	such child re	eside with you	?				
Yes 🔲 No If "No"	•				•					
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coverage, should be attache	ed to this form.		_				_			
If coverage was lost under the pr		alth plan with	in 30 da	ys of the dat	e of this appli	cation, lis	t reason	the cov	erage wa	
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1975 Tamarack Road P.O. Box 1009 Newark, OH 43058-1009 (800) 423-3151

Name:	SSN:
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Dependent (Children					Relation	nship (Cl	neck or	ne)
Full Name	Date of Birth	Height/Weight	Male or Female	Full-Time Student? (Y/N	You and/or your spouse provide over 50% Support	Natural Child	Adopted Child	Step- Child	Custody or Guardian- ship*
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