Group Employee Enrollment Form

The United States Life Insurance Company in the City of New York
New York, New York
Administrative Office: PO Box 30066, Tampa, FL 33630-3066
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Completing Your **GROUP ENROLLMENT FORM** 1. **Fully complete** each section 2. **Sign and date** Refusal/Authorization Section, as needed.	Group Policy No.(s)	☐ NEW ENROLLMENT ☐ CHANGE IN ENROLLMENT

1. PERSONAL DATA: (Must always be completed)

Billing Location	Class	Social Security No.	Last Name	First Name	Initial

Sex ☐ Male ☐ Female	Date of Birth MM/DD/YY	Street Address	City	State	Zip Code

Name of Employer	Location	Salary $ Per

Occupation	Title	Date of Full-Time Employment MMDDYYYY	No. Hours Worked Per Week	☐ Union ☐ NonUnion

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced | Dependent Children ☐ No ☐ Yes | If Yes, #

2. ENROLLMENT

If enrolling for Dental or Vision benefits, list name, relationship to you, and date of birth for each dependent to be insured.
PLEASE LIST ADDITIONAL DEPENDENTS ON A SEPARATE SHEET.
Give policy number, name and address of current employer's prior group insurance carrier, if you and your dependents were insured. Indicate your effective and termination dates of coverage also.

If high/low dental, please select one.

Name	Relationship Self	Sp.	Ch.	Date of Birth MM/DD/YY	Sex
SELF	X				

☐ High
☐ Low

3. Supplemental Life Benefit: If this benefit is a plan option and you wish to enroll for Supplemental Life coverage, please indicate

Life Amount for: Employee $	**Spouse $**	**Dependent $**

4. Supplemental AD&D Benefit: If this benefit is a plan option and you wish to enroll for Supplemental AD&D coverage, please indicate

AD&D Amount for: Employee $	

5. Beneficiary Designation: as is

EX: MARY A. JONES, WIFE NOT MRS. JOHN JONES	Name	Address	Telephone#	Social Security#	Relationship

6. REFUSAL OF COVERAGE: (Note: Benefits provided on a non-contributory basis cannot be refused)

I was given the opportunity to enroll in this plan for group insurance offered by my employer/association and insured by The United States Life Insurance Company in the City of New York.

I am refusing:

- ☐ LTD
- ☐ STD
- ☐ Life/AD&D
- ☐ Dependent Life
- ☐ All coverages offered

Dental:

- ☐ Employee & Dependents
- ☐ Spouse
- ☐ Child(ren)
- ☐ All Dependents

Vision:

- ☐ Employee & Dependents
- ☐ Spouse
- ☐ Child(ren)
- ☐ All Dependents

MUST ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD COVERAGE:

Are you or your dependents now covered by any other group plan? ☐ YES ☐ NO (Your dependent(s) may be insured by this Plan even if they are insured elsewhere)

If Yes: Policyholder's Name Carrier

I understand that if I am refusing insurance because I am insured under another applicable insurance plan, I may be added to this plan under the same terms and conditions with respect to pre-existing conditions and their limitations as if I enrolled when initially eligible. I understand that I must request enrollment within 31 days following the termination of the other applicable insurance plan.

If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage.

I must furnish, at my expense, **evidence of insurability** satisfactory to The United States Life Insurance Company in the City of New York. If I later wish to enroll in any other coverage that is now being refused.

DATE OF REFUSAL ***SIGNATURE IF REFUSING ANY COVERAGE***

***IF REFUSING ALL COVERAGES, IT IS NOT NECESSARY TO COMPLETE THE REMAINDER OF THIS FORM.**

7. Important Notice

The group policy is a contract between the Company and the Policyholder. It may be changed, reduced, restricted or ended without consent of any Insured Person. It may occur at a time when the certificate holder's health status has changed and may affect his/her ability to procure individual insurance.

8. AUTHORIZATION:

- I hereby represent that all information furnished is true to the best of my knowledge.
- I request group insurance for which I am or may become eligible.
- If I am required to contribute to the premium for any coverage elected on this form, I hereby authorize my employer to deduct such contributions in advance from wages due me, for remittance to The United States Insurance Company in the City of New York.
- I designate the beneficiary named on this form to receive the proceeds, if any, payable upon my death.
- If dental care or health care is provided by a participating provider, all benefits will be paid directly to the provider by The United States Insurance Company in the City of New York.

DATE SIGNED ***APPLICANT'S SIGNATURE***