



SMALL GROUP INSURANCE ENROLLMENT FORM

New Employee Initial Enrollee Late Entrant Change of Coverage

Group Policy # _____ Employer's Telephone # _____

Group Name _____

If declining any available coverage, please sign attached Refusal of Coverage.

EMPLOYEE INFORMATION *(please print)*

Social Security No. _____

Last Name _____ First Name _____ MI _____

Address _____

City _____ State _____ Zip Code _____

Gender Male Female Date of Birth _____

Occupation and duties _____

Full time hire date _____ Hours worked per week (Minimum 30) _____

Effective date _____ Rehire date _____

Base earnings (no overtime)..... \$ _____

Annual Monthly Semi-monthly Bi-weekly Weekly Hourly

COVERAGE

Coverages applied for Life and AD&D Short Term Disability Long Term Disability Dental

INFORMATION FOR DENTAL INSURANCE

Type of Dental Coverage Employee Employee & 1 Dependent Employee & 2 or more dependents

	Last Name	First	MI	Social Security Number	Date of Birth	Full-time Student
Spouse	_____	_____	_____	_____	_____	N/A
Child	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
Child	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you or any of your dependents covered for dental insurance under another policy? Yes No

continued on reverse

BENEFICIARY INFORMATION FOR LIFE INSURANCE

PRIMARY BENEFICIARY

Last Name	First	MI	Relationship to Insured	%
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____

CONTINGENT BENEFICIARY

Last Name	First	MI	Relationship to Insured	%
1. _____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____

STATEMENT OF UNDERSTANDING

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 authorization at any time upon written notice to the Employer. I understand that if I am not actively at work on the date coverage would otherwise take effect, that my coverage will be delayed until I return to full time active work.

Any person who, knowingly and with intent to defraud any insurance company or other person, 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.

The following states require that alternate statements regarding insurance fraud be given. If you are a resident of any of the following states, please consider the following statements as replacements for the above statement.

Florida – Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

New Jersey – Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Virginia – Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

I, the undersigned, certify all statements are true and complete to the best of my knowledge and belief.

Signature _____ Date _____

YOU MUST COMPLETE EVIDENCE OF INSURABILITY FORM IF:

1. You are applying for life insurance more than \$25,000 for a group of 2-5 employees.
2. You are applying for life insurance more than \$50,000 for a group of 6-9 employees.
3. You are applying for coverage 31 days or later after you become eligible for the coverage (late entrant).
4. You are requested by Shenandoah Life to furnish evidence of insurability.



Post Office Box 12847 Roanoke Virginia 24029 800.848.5433 www.shenlife.com

Group Name _____ Policy # _____

Employee Last Name _____ First Name _____ MI _____

Social Security No. _____

REFUSAL OF COVERAGE

Coverages refused (check all that apply)

Life and AD&D Short Term Disability Long Term Disability Dental

I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, some benefits may be limited and/or I will be required to furnish evidence of insurability at my own expense, and the company will have the right to refuse any request.

If declining coverage, please sign.

Signature _____ Date _____