AmWINS Group Benefits

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ENROLLMENT FORM FOR GROUP INSURANCE

GROUP NAME:	GROUP POLICY #

A. Employee Information (Complete for ALL Enrollments)

Social Security Number	Last Name	First Name	MI

Street Address	City	State	ZIP	Date of Birth

☐ Male ☐ Female	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Date of Full-Time Hire	Occupation

B. Completed By Employer

Annual Earnings: $ Average # Hours Worked Per Week:

C. Product Selection (Complete for ALL Enrollments)

NOTE: Please mark each box for coverage for which you are applying.

Group Life AD&D	Dependent Life	Short Term Disability	Long Term Disability
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Dental: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family ☐ No Coverage

Vision: ☐ Employee Only ☐ Employee & 1 Dependent ☐ Family ☐ No Coverage

Voluntary Product Selection

Voluntary Life ☐ Yes ☐ No	Voluntary STD ☐ Yes ☐ No	Voluntary LTD ☐ Yes ☐ No
Voluntary Dental ☐ Yes ☐ No	Voluntary Vision ☐ Yes ☐ No	

D. Dependent Information (Dental or Vision Coverage) List Dependents to be Covered.

First Name	Last Name	Relationship	DOB	First Name	Last Name	Relationship	DOB
First Name	Last Name	Relationship	DOB	First Name	Last Name	Relationship	DOB

E. Beneficiary Information (Complete ONLY for Life Enrollments)

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number

F. REFUSAL OF COVERAGE (Complete ONLY for Waiver of Group Insurance Coverage)

The group program has been offered to me, and after carefully considering its benefits, I have decided:
(Please indicate your choice)
☐ (a) not to enroll myself or dependents in the Program
☐ (b) not to enroll my dependents in the Program

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.

G. Signature (Complete for Enrollment or Refusal)

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.

_____ _____

Signature Date Print Name