

MEDICAL LIFE
INSURANCE COMPANY

ENROLLMENT FORM

PLEASE TYPE OR PRINT WITH BLACK PEN.

NAME OF EMPLOYEE — LAST		FIRST	MIDDLE INITIAL	SEX M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH MO / DAY / YEAR	DATE OF HIRE (FULL TIME) MO / DAY / YEAR
SOCIAL SECURITY NO. (THIS IS YOUR CERTIFICATE NO.)		EARNINGS \$ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual		JOB TITLE		CLASS
EMPLOYER			GROUP NO./DIVISION NO.	LOCATION		

BENEFICIARY (Must Be Completed) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. SEE REVERSE FOR DETAILS.

First Name	Last Name	Date of Birth	Social Security Number	Relationship	Benefit %
Primary		MO / DAY / YEAR			%
Primary		MO / DAY / YEAR			%
Contingent		MO / DAY / YEAR			%
Contingent		MO / DAY / YEAR			%

COVERAGE SELECTION: YOUR EMPLOYER HAS DETAILS ABOUT THE BENEFIT PLAN(S) AVAILABLE TO YOU.

Dependent Life <input type="checkbox"/> YES <input type="checkbox"/> NO	STD Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO	LTD Benefit <input type="checkbox"/> YES <input type="checkbox"/> NO	Supplemental Life/Amt <input type="checkbox"/> YES <input type="checkbox"/> NO \$	Supplemental AD&D/Amt <input type="checkbox"/> YES <input type="checkbox"/> NO \$	Other \$ <input type="checkbox"/> YES <input type="checkbox"/> NO
--	---	---	--	--	--

I HEREBY REQUEST TO BE INSURED AND AUTHORIZE DEDUCTIONS, IF ANY, FROM MY COMPENSATION FOR MY SHARE OF THE COST OF THE BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE GROUP POLICY (IES) ISSUED TO THE EMPLOYER LISTED ABOVE. I UNDERSTAND THAT IF I AM NOT ACTIVELY AT WORK ON THE EFFECTIVE DATE OF MY COVERAGE, MY INSURANCE WILL NOT BEGIN UNTIL THE DAY I RETURN TO WORK. FOR THOSE COVERAGES I HAVE DECLINED, I UNDERSTAND THAT IF I CHOOSE TO ENROLL AT A LATER DATE, MY COST MAY BE HIGHER AND A HEALTH QUESTIONNAIRE MAY BE REQUIRED.

WARNING: 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 for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties. (not enforceable in Oregon or Virginia)

SIGNATURE OF EMPLOYEE OR MEMBER _____ DATE SIGNED MO / DAY / YEAR

FOR MLI USE ONLY Effective Date / /

ML9009S R2/98 EMPLOYER: If self-administered, keep original; otherwise send enrollment form to Medical Life and keep a copy in employee's file.