CONTINENTAL AMERICAN INSURANCE COMPANY

300 Southborough Drive, Suite 200, South Portland, Maine 04106

EMPLOYEE ENROLLMENT FORM FOR
GROUP LIFE AND AD&D INSURANCE

This Area for Agent or Plan Administrator Use Only.

Group Number(s):	Effective Date of Coverage:
24597	The first day of _____, _____ (Month / Year)

To enroll, please type or print in dark ink and return to your Agent or Employer. Keep a copy for your records. Any changes must be initialed and dated by the Applicant.

Failure to sign and date this application and to accurately complete the questions on this application may affect the existence or amount of coverage.

Last Name	First Name	Middle Initial	Birth Date (MM/DD/YY)	Gender ☐ M ☐ F	Social Security No.

Home Address Number/Street	City	State	Zip

Home Phone Number ( )	Employer Name	Your Work Location/Site
	Pueblo of Zuni	

Date of Hire	Occupation	Annual Income $	Your scheduled work hours per week

MY SIGNATURE ON THIS APPLICATION REPRESENTS THAT:

1. I authorize my employer's Payroll Department to deduct the required premium from my salary for the insurance coverage for which I am applying. These authorized deductions may be made at intervals mutually agreed upon by my employer and Continental American Insurance Company, and are to be paid to Continental American Insurance Company when due. I understand I am responsible for paying any premium due for which the Payroll Department cannot make a regularly scheduled deduction. To revoke this authorization, I must notify my Payroll Department in writing to cancel the premium deductions. I must abide by any rules specified by the employer's benefit plan and/or by law.
2. I am applying for the coverages designated for which I am eligible under my employer's plan with Continental American Insurance Company.
3. All of the information on this application is complete, correct and true to the best of my knowledge and belief.
4. I understand that I must be actively at work on the effective date or coverage will be deferred until I return to work. I also understand that dependent coverage will not become effective while the dependent is in a hospital or similar facility.
5. **FOR LIFE/AD&D INSURANCE:** I designate the beneficiary(ies) named in the beneficiary section of this application to receive any benefits payable in the event of my death.

NOTICE: For this group insurance plan to become effective, a minimum number of employees must apply. Your coverage will not go into effect unless the minimum requirement is met.

The insurance applied for shall be in force as of the date described in the certificate provided the Company approves my application without any modifications as to the plan amount or premium. If the application is approved with any modification, the insurance shall not take effect until the certificate has been delivered to and accepted by me. Furthermore, the insurance shall not take effect if there has been a change in the health of any person to be insured as stated since the date of application.

Dated at: _____ On: _____/_____/_____
City State Month Day Year

_____ _____
Signature of Employee Printed Name of Employee

_____ _____
Enroller/Agent Agent Number