# ENROLLMENT FORM FOR GROUP INSURANCE

Group Policy Number |

Group Name (Please Print) Candy Fleet Corporation

State LA

Employee Last Name | First Name | M.I.

Street Address | City | State | Zip code

Date of Birth | Social Security Number | Male ☐ Female ☐ | Single ☐ Married ☐ Divorced ☐ Widowed ☐

Occupation | Full Time Employment Date | Income: *Office Use Only* | Average Hours Worked Per Week

Beneficiary Last Name | First Name | M.I. | Relationship

Street Address | City | State | Zip Code

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. (Choose the Appropriate Answer)

| Short Term Disability | Long Term Disability | Life/AD&D | Dependent Life |
|---|---|---|---|
| ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| ☐ No | ☐ No | ☐ No | ☐ No |

Signature of Applicant | Date Applicant Signed

Waiver Complete Only For Waiver of Group Insurance Coverage

This group program has been offered to me and after seriously 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. I understand if a physical examination for future medical information is required, it will be at my own expense.

Signature of Applicant | Date Applicant Signed

For Company Use | Effective Date | LTD Effective Date | Employee Class | Basic Amount | Optional Amount