PLAN ADMINISTRATION, LTD Group Enrollment Card			Social Security #			Pal #		Cert #
Name of Employer, Association or Union								
EMPLOYEE'S NAME *(Please Print)*	Last		First	MI		Sex M F		Class
EMPLOYEE'S RESIDENCE								
Salary $ Union ☐ Non Union ☐			Date of Birth	Date Employed Full Time		Effective Date		
Occupation		Hrs Wrkd	Other Benefits (circle one) Dental / Vision Type of Coverage: Employee Employee/Child Employee/Spouse Full Family					
Benefit Type (check all that apply)	Life & AD&D ☐	STD ☐	LTD ☐	Dep ☐	Supp/Vol ☐			
	Other [specify]							
BENEFICIARY DESIGNATION (Please Print)	First Name		MI	Last Name		Relationship		
I (1) Request the group insurance coverage for which I am or may become eligible (2) authorize deductions from my pay or dues for my share of the cost, if any, and (3) designate the beneficiary named on this card to receive the proceeds, if any, payable if I die. Date: ______________________________ Employee's Signature: ______________________________								

Do not fill in shaded cells

Your beneficiary is the person you wish to receive the benefit