GROUP TERM LIFE ENROLLMENT

EMC National Life Company

EMPLOYER: **Two K General Company**			**TO BE COMPLETED BY POLICYHOLDER**
DATE OF EMPLOYMENT	POLICY # **GL-0906**	NEW ENROLLMENT _____ CHANGE IN COVERAGE ONLY _____	AMOUNT $ 50,000

NAME OF EMPLOYEE

LAST NAME | FIRST NAME | MIDDLE NAME | SOCIAL SECURITY # | BIRTHDATE | GENDER

RESIDENCE ADDRESS

STREET | CITY | STATE | ZIP CODE

PRIMARY BENEFICIARY

LAST NAME | FIRST NAME | MI | RELATIONSHIP

ADDITIONAL PRIMARY BENEFICIARY(IES)

CONTINGENT BENEFICIARY

LAST NAME | FIRST NAME | MI | RELATIONSHIP

ADDITIONAL CONTINGENT BENEFICIARY(IES)

Do you have Eligible Dependents?

☐ Yes ☐ No

If the above elect or decline boxes are left blank, coverage will be considered declined.

I've been told about, understand and request (or refuse as indicated) the insurance under the group insurance policy issued by EMC National Life Company to my employer. I authorize payroll deduction for supplemental insurance I elect. I understand that even though I have elected the insurance provided, Medical Evidence of Insurability may be required. Late applicants are always subject to proof of good health. Insurance will not take effect until approved by EMC National Life Company.

NOTE: Any person 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.

VERIFICATION: To the best of my knowledge, all information shown is correct, and by signing this form I am indicating that I understand all information given is subject to verification.

SIGNATURE OF EMPLOYEE _____ DATE COMPLETED _____

HOME OFFICE USE ONLY

LH707.01