

NATIONAL BENEFITS, INC.

ENROLLMENT APPLICATION

NAME OF EMPLOYER:		EFFECTIVE:	
GROUP NO.	S.S.#	DATE OF HIRE	Loc #
		ORIGINAL DATE OF COVERAGE WITH EMPLOYER	
I APPLY FOR		EFFECTIVE DATE OF COVERAGE WITH NBI	
<input type="checkbox"/> SINGLE <input type="checkbox"/> EE/CHILD <input type="checkbox"/> LIFE ONLY <input type="checkbox"/> COBRA <input type="checkbox"/> EE/SPOUSE <input type="checkbox"/> FAMILY <input type="checkbox"/> I DECLINE COVERAGE			
EMPLOYEE NAME _____			
LAST NAME _____		FIRST NAME _____	
ADDRESS _____		MIDDLE INITIAL _____	
STREET _____	APT. NUMBER _____	<input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH _____
CITY _____	STATE _____	MONTH _____ DAY _____ YEAR _____	
	ZIP CODE _____	NETWORK: _____	

DEPENDENT INFORMATION

NAME OF SPOUSE	DATE OF BIRTH	MONTH _____ DAY _____ YEAR _____	IS SPOUSE EMPLOYED?
IF SPOUSE EMPLOYED PLEASE PROVIDE EMPLOYERS NAME & ADDRESS _____			
DOES YOUR SPOUSE HAVE OTHER INSURANCE COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF YES PLEASE PROVIDE THE NAME & ADDRESS & PHONE # OF THE OTHER INSURANCE CARRIER _____			
NAME OF CHILD	DATE OF BIRTH	MONTH _____ DAY _____ YEAR _____	TYPE OF COVERAGE
			<input type="checkbox"/> SINGLE <input type="checkbox"/> EE/CHILD
			<input type="checkbox"/> EE/SPOUSE <input type="checkbox"/> FAMILY
			<input type="checkbox"/> COLLEGE STUDENT <input type="checkbox"/> COLLEGE STUDENT DISABLED
NAME OF CHILD	DATE OF BIRTH	MONTH _____ DAY _____ YEAR _____	<input type="checkbox"/> SINGLE <input type="checkbox"/> EE/CHILD
			<input type="checkbox"/> EE/SPOUSE <input type="checkbox"/> FAMILY
			<input type="checkbox"/> COLLEGE STUDENT <input type="checkbox"/> COLLEGE STUDENT DISABLED
NAME OF CHILD	DATE OF BIRTH	MONTH _____ DAY _____ YEAR _____	<input type="checkbox"/> SINGLE <input type="checkbox"/> EE/CHILD
			<input type="checkbox"/> EE/SPOUSE <input type="checkbox"/> FAMILY
			<input type="checkbox"/> COLLEGE STUDENT <input type="checkbox"/> COLLEGE STUDENT DISABLED
NAME OF CHILD	DATE OF BIRTH	MONTH _____ DAY _____ YEAR _____	<input type="checkbox"/> SINGLE <input type="checkbox"/> EE/CHILD
			<input type="checkbox"/> EE/SPOUSE <input type="checkbox"/> FAMILY
			<input type="checkbox"/> COLLEGE STUDENT <input type="checkbox"/> COLLEGE STUDENT DISABLED
LIFE INSURANCE AMOUNT \$ _____			
BENEFICIARY DESIGNATION	NAME	RELATIONSHIP	
ADDRESS _____			
ENROLLED UNDER MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO			
IF YES, WHAT DATE ENROLLED? _____			
ADDITIONAL INFORMATION			
* IF FULL-TIME COLLEGE STUDENT, PLEASE PROVIDE PROOF OF FULL TIME STATUS IN THE FORM OF A SEMESTER BILL.			
EMPLOYEE SIGNATURE _____ DATE _____			

I REPRESENT THAT EACH OF THE ABOVE STATEMENTS AND ANSWERS ARE COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE.