Colonial Life & Accident Insurance Company | GROUP ENROLLMENT FORM

Proposed Named Insured: _____ **Gender:** ___ **Date of Birth:** _____ **SSN:** _____

Home Address: _____ **Phone:** _____

Occupation/Job Title: _____ **Employee Class:** _____ **Hire Date:** _____

Annual Salary: $ _____ **Hrs/Wk:** ___ **Employee ID:** _____ **Section/Dept #:** _____

Employer: Pasadena ISD **FICA:** Full ___ Exempt ___ Medicare only ___

Employer Address: 1515 Cherrybrook Lane Pasadena, TX 77502 **Business Phone Number:** (713) 740 -0121

Are any eligible dependent children applying for coverage? If yes, provide identifying information below.	Yes □ No □
Is your spouse applying for coverage? If yes, provide identifying information below.	Yes □ No □

Spouse/Dependent Name	Relationship to Proposed Named Insured	Date of Birth	SSN

Type of Coverage	Base Plan Code	Total Premium	Rider Plan Code	Unit and/or Rider Amount	P = Pre-Tax A = After-Tax	Monthly Premium
Cancer						
□ Named Insured □ Named Insured & Family					P □ A □	
				Total Monthly Premium $		

Are you or any person to be covered Medicare eligible? If yes, the Important Notice to Persons on Medicare will be provided.	Yes □ No □

Have you tested positive for the HIV virus or its antibodies, or been diagnosed with or received medical treatment from a member of the medical profession for acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)?	Yes □ No □	Yes □ No □	Yes □ No □

I understand that the coverage applied for will not pay benefits for any loss incurred during the first 12 months after the issue date for a disease or physical condition that I now have or have had in the past. Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison. By applying for the coverage indicated above, I am requesting cancellation of existing similar Colonial coverage (base plan and all applicable riders) if the coverage applied for is issued. If, for any reason the coverage applied for is not issued, this request for cancellation shall be null and void.

Signed at: **City** _____ **State** ___ **Agent Name** (if present) _____

Date **Signature of Proposed Named Insured** (if applicable) **Signature of Licensed Agent** (if applicable) **Code #**