Assurity
Assurity℠ Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

GROUP PARTICIPANT ENROLLMENT FORM

PLEASE PRINT WITH BLACK INK

☐ **New Enrollee**
☐ **Coverage Change**

Group Name _____ Location _____ Requested Issue Date (MM/DD/YYYY) / /

A. Participant Information

Applicant's Legal Name *First, Middle, Last*		Date of Birth *(MM/DD/YYYY)* / /
Applicant's Mailing Address *Street Address*	*City* *State* *ZIP+4*	
Applicant's Email Address		Personal Phone Number ( )
☐ Male ☐ Female	Social Security No.	Birth State/Country
Date of Employment *(MM/DD/YYYY)* / /	Hours per week	Annual Salary $

Are you employed at least 20 hours per week, working your normally scheduled hours and able to perform the regular duties of your job? ☐ Yes ☐ No
If NO, please explain.

During the past **12 months**, has any Proposed Insured used any form of tobacco or nicotine-based products or substitutes such as patches or gum?
Applicant..... ☐ Yes ☐ No
Spouse ..... ☐ Yes ☐ No

SPOUSE INFORMATION:

Spouse's Legal Name *First, Middle, Last*		Date of Birth *(MM/DD/YYYY)* / /
☐ Male ☐ Female	Social Security No.	Birth State/Country

CHILD INFORMATION: If additional space is needed, please attach a separate sheet of paper.

Child's Legal Name *First, Middle, Last*	Relationship to Applicant	☐ Male ☐ Female	Date of Birth *(MM/DD/YYYY)* / /
Child's Legal Name *First, Middle, Last*	Relationship to Applicant	☐ Male ☐ Female	Date of Birth *(MM/DD/YYYY)* / /
Child's Legal Name *First, Middle, Last*	Relationship to Applicant	☐ Male ☐ Female	Date of Birth *(MM/DD/YYYY)* / /
Child's Legal Name *First, Middle, Last*	Relationship to Applicant	☐ Male ☐ Female	Date of Birth *(MM/DD/YYYY)* / /

B. Voluntary Benefit Election — Completion of a Statement of Health and/or Statement of Insurability form may be required for coverage to be approved.

Note: Coverage is for new elections only. Existing coverage will remain in force unless cancelled by You.
Coverage not elected will be considered refused even if not specifically declined.

Critical Illness	☐ Yes ☐ No	Applicant Benefit Amount: $	☐ Applicant Only ☐ Applicant/Child	☐ Applicant/Spouse ☐ Family
Accident Expense	☐ Yes ☐ No	☐ Applicant Only ☐ Applicant/Child	☐ Applicant/Spouse	☐ Family
Hospital Indemnity	☐ Yes ☐ No	☐ Applicant Only ☐ Applicant/Child	☐ Applicant/Spouse	☐ Family
Term Life	☐ Yes ☐ No	☐ 10-Year ☐ 20-Year ☐ To Age 70		
	Applicant Benefit $	Spouse Term Rider ☐ Yes ☐ No	Children's Term Rider ☐ Yes ☐ No	
Whole Life	☐ Yes ☐ No	Applicant Benefit $	Spouse Whole Life Benefit $	Child Whole Life Benefit $