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GROUP INSURANCE ENROLMENT CARD

PLEASE COMPLETE FORM IN BLOCK LETTERS

POLICYHOLDER NAME

[Grid for Policyholder Name]

ASSOCIATION EMPLOYER CREDIT UNION UNION

APPLICANT'S SURNAME

[Grid for Applicant's Surname]

DATE OF BIRTH

[Grid for Date of Birth: m m d d y y]

SEX

M F

APPLICANT'S FIRST NAME

[Grid for Applicant's First Name]

MARITAL STATUS

SINGLE MARRIED

DO YOU HAVE ANY OTHER FORM OF INSURANCE? TICK ✓

MOTOR FIRE BURGLARY MARINE LIFE MEDICAL IF YES, SPECIFY: _____

BENEFICIARY'S NAME (SURNAME FIRST) - applicable to health/life

[Grid for Beneficiary's Name]

BENEFICIARY'S RELATIONSHIP TO APPLICANT

[Grid for Beneficiary's Relationship]

APPLICANT'S OCCUPATION

[Grid for Applicant's Occupation]

APPLICANT'S EARNINGS

[Grid for Applicant's Earnings]

HOW ARE EARNINGS PAYABLE

Hourly Weekly Monthly Annually

DATE EMPLOYED

[Grid for Date Employed: m m d d y y]

DATE CONFIRMED

[Grid for Date Confirmed: m m d d y y]

EFFECTIVE DATE

[Grid for Effective Date: m m d d y y]

AMOUNT OF LIFE INSURANCE

[Grid for Amount of Life Insurance]

AMOUNT OF AD&D INSURANCE

[Grid for Amount of AD&D Insurance]

HEALTH INSURANCE

YES NO

DEPENDENTS TO BE COVERED?*

YES NO

*If Yes, list below

EMPLOYEE CATEGORY: EMPLOYEE ONLY EMPLOYEE & ONE EMPLOYEE & FAMILY

ELIGIBLE DEPENDANTS TO BE INSURED

NAME	DATE OF BIRTH	RELATIONSHIP	EFFECTIVE DATE OF COVERAGE

I HEREBY apply for insurance under Policyholder's Group Plan and Authorize the deduction from my pay (if applicable) of any contribution I must make towards the cost of these or any future benefits. I also agree to produce evidence of age if required. If any beneficiary named above dies before me the interests of such beneficiary shall unless otherwise provided above accrue to the surviving beneficiaries or beneficiary or if none of my estate. I reserve the right to change any beneficiary named above.

Applicant's Signature

Policyholder's Signature & Stamp

Date

FOR OFFICIAL USE ONLY

E. Only E. + One E. + Family

REMARKS

EFFECTIVE DATE OF CHANGE: