ASSURANT EMPLOYEE BENEFITS

Group Life Insurance Enrollment Application

Group No. 16,555

Employee Name (Last, First, Middle)			Social Security #	
Mailing Address		Home Telephone # ( )		Sex [] Male [] Female
Date of Birth	Marital Status [] Single [] Widowed [] Married [] Divorced		Date of Employment	
Name of Employer			Occupation Classification	
Primary Beneficiary(ies)		Date of Birth Mo. / Day / Year	Social Security #	Relationship to Employee
1				
2				
3				
Contingent Beneficiary(ies)				
1				
2				
3				

1) If beneficiary is not related to you, please provide Date of Birth, Social Security number, and full address. Give FULL names and relationships of each beneficiary. 2) Proceeds will be paid in equal shares to those primary beneficiaries who survive you. If no primary beneficiaries survive you, the proceeds will be paid in equal shares to the surviving secondary beneficiaries. 3) If your designation does not fit in the above arrangement, please contact PSBA Insurance Trust for the appropriate forms.

IMPORTANT NOTICE TO APPLICANTS – PLEASE READ CAREFULLY

My signature on this application certifies that I:

1) Apply for the coverages designated for which I am eligible under my employer's plan with Assurant Employee Benefits. 2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health satisfactory to Assurant Employee Benefits. 3) Authorize any required deductions from my earnings. 4) Designate the beneficiary named on this application to receive any benefits payable in the event of my death. 5) Representation that all of the information on this application is complete, correct and true to the best of my knowledge and belief. 6) Understand that I must be actively at work the number of hours specified in my policy/participation agreement to remain insured.

Any person who 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.

This will certify that I HAVE read and understand the above important notice.

Employee's Signature _____ Date _____