Enrollment Form

For group coverage – life only

ADVANCE Insurance Company of Kansas SM

www.advanceinsurance.com

Section 1

Name _____
Last (Sr., Jr., etc.) First MI

Residential Address _____
Street

_____
City State ZIP Code + 4

Mailing Address _____
If different from residential address
Street

_____
City State ZIP Code + 4

Married? ☐ Yes ☐ No Date of Marriage _____
MM DD YYYY

Employed by _____

Actively working _____ hrs weekly for this employer

Date of Birth _____
MM DD YYYY

Social Security No. _____

Gender ☐ Male ☐ Female

Home Phone _____
Area Code

Work Phone _____
Area Code

Cell Phone _____
Area Code

Group No. _____

Date of Full-Time Hire _____
MM DD YYYY

Section 2

Reason for change in employment: ☐ part time to full time ☐ temporary to permanent ☐ rehire/recall ☐ other (specify)

Date this occurred _____
MM DD YYYY

Employee Occupation/Job Title		Earnings $ _____ ☐ HR ☐ WK ☐ MO ☐ ANN	Eligible unmarried dependent children under 23? ☐ Yes ☐ No
Are you currently working for this employer? ☐ Yes ☐ No	Does your spouse work for this employer? ☐ Yes ☐ No	Applying for: Dependent Life ☐ Yes ☐ No	Short Term Disability ☐ Yes ☐ No / Long Term Disability ☐ Yes ☐ No

	Last	First	M.I.	Street	City	State	Relationship	Age
Primary Beneficiary	1							
	2							
Contingent Beneficiary	1							
	2							

If this space is inadequate for your beneficiary(ies), attach a separate signed and dated list providing complete information.

Section 3

Beneficiary Tips

- A primary beneficiary will receive death proceeds upon the death of the insured.
- A contingent beneficiary will receive death proceeds only if primary beneficiary(ies) are deceased.
- The form must be signed and dated to be valid.

I understand that if I am not at work on the effective date of my coverage, my life and/or disability (if applicable) insurance will not begin until the day I return to work. If I do not enroll when first eligible, I understand evidence of insurability will be required, that I will be responsible for any fees or cost associated with the physical or for obtaining medical records as a late enrollee and that life and/or disability (if applicable) insurance coverage may be declined.

Your signature & date required _____ **Date** _____

RESET FORM