



The First Rehabilitation Life Insurance Company of America

600 Northern Boulevard, Great Neck, New York 11021-5202
(516) 829-8100(800) 365-4999 Fax: (516) 829-8211
www.firstrehab.com

POLICYHOLDER (employer) \_\_\_\_\_

GROUP ENROLLMENT AND/OR CHANGE FORM

EMPLOYEE (last, first, middle initial) \_\_\_\_\_ F M
Street \_\_\_\_\_ Date of Birth (mm/dd/yyyy) \_\_\_/\_\_\_/\_\_\_
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_
Hours worked per week \_\_\_\_\_ Annual Salary \$ \_\_\_\_\_ Date of F/T hire (mm/dd/yyyy) \_\_\_\_\_
Job title \_\_\_\_\_ Social Security Number \_\_\_\_\_

TYPE OF COVERAGE (Policy Number) (check all that apply)
Not all policies may be available through your employer.

NEW ENROLLMENT (date) \_\_\_\_\_
CHANGE IN ENROLLMENT (date) \_\_\_\_\_

- Dental
Vision
Life
GMRP
XGMM
LTD

- TYPE OF CHANGE (check all that apply)
Name
Address
Delete a Dependent
Add a Dependent
Other
Marriage
Divorce
Birth
Beneficiary

DEPENDENT COVERAGE (If more space is needed, attach extra copies or pages.)

Spouse (last, first, middle initial) \_\_\_\_\_

F M Date of Birth (mm/dd/yyyy) \_\_\_/\_\_\_/\_\_\_

Child (last, first, middle initial) \_\_\_\_\_

F M F/T Student Yes No Date of Birth (mm/dd/yyyy) \_\_\_/\_\_\_/\_\_\_

Child (last, first, middle initial) \_\_\_\_\_

F M F/T Student Yes No Date of Birth (mm/dd/yyyy) \_\_\_/\_\_\_/\_\_\_

Child (last, first, middle initial) \_\_\_\_\_

F M F/T Student Yes No Date of Birth (mm/dd/yyyy) \_\_\_/\_\_\_/\_\_\_

LIFE/LTD BENEFICIARY

Primary (last, first, middle initial) \_\_\_\_\_ Relationship \_\_\_\_\_

Primary (last, first, middle initial) \_\_\_\_\_ Relationship \_\_\_\_\_

Contingent (last, first, middle initial) \_\_\_\_\_ Relationship \_\_\_\_\_

GMRP: Amount of Coverage Requested \$ \_\_\_\_\_

LTD: I certify that I am not currently disabled and that I am performing all duties required for my job on a full time basis.

CONTRIBUTORY BENEFITS ONLY

Request to Participate I hereby request to participate in the insurance program. I agree to contribute as required.

Waiver of Insurance I do not wish to participate in the insurance program. I understand that if I wish to participate at a later date, my benefits may be denied or reduced.

The information provided above is true and complete to the best of my knowledge and belief.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

NOTICE (not applicable to life insurance): 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.