



Voluntary Life Enrollment Application

GE Group Life Assurance Company
PO Box 1471
Waterbury CT 06721

Employer	Account Number
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1. Employee Information

Name (Last, First, M.I.)	Social Security Number	Date of Birth
Address (No., Street, City, State, ZIP Code)		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Home Phone #	E-mail Address	

2. Employment Information

Regular Place of Employment (City, State)	Date employed Full-time (Mo., Day, Yr.)	Basic Earnings \$ _____ per _____
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3. Spouse Information

Name of Spouse (Last, First, M.I.)	Social Security Number	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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4. Beneficiary Designation - (See plan administrator for beneficiary instructions)

Primary Beneficiary (Last Name, First Name & M.I.)/Relationship to Employee	Address
Contingent Beneficiary (Last Name, First Name & M.I.)/Relationship to Employee	Address

5. Coverage Information

Coverage Requested: Employee Only Employee and Children Employee and Spouse Employee and Eligible Dependents

Benefit Requested: Employees may elect an amount, in \$10,000 increments, up to \$300,000 or five times salary, whichever is less.* Spouse may elect amounts in \$5,000 increments up to a maximum of 50% of the employee's coverage amount or \$50,000, whichever is less. Indicate amounts elected below (Check with your employer for the available non-medical issue amount):

If sections 1-6 are incomplete your benefit will be limited to the non-medical issue amount. Please see reverse side if benefits elected are in excess of the non-medical issue amount.

Employee- \$ _____,000.00 (minimum of \$20,000)** Spouse- \$ _____,000.00 (minimum of \$10,000)**

*In Texas, the total amount of Life Insurance (basic life plus voluntary life) cannot exceed the greater of \$250,000 or seven times salary. In Wisconsin, the total amount of Life Insurance (basic life plus voluntary life) cannot exceed \$200,000.

**In Washington, the Employee minimum is \$30,000 and the Spouse minimum is \$15,000.

6. Have you or your dependents used any tobacco products in the past 12 months?

Employee: Yes No Spouse: Yes No

7. Application & Authorization Section

I have read and personally responded to each of the preceding questions and have confirmed that the information is correct as to myself and my dependents.

I request insurance under the group coverage issued to my employer by GE Group Life Assurance Company (GEGGLAC); authorize deductions from my earnings of any required contributions for any insurance for which I am or may later become eligible; and designate the beneficiary(ies) shown to receive all sums which may become due on account of my death under this group coverage. I certify that: (1) I am employed by the employer listed and at present am working at least 30 hours per week for this employer at the regular place of business; (2) the information shown is correct; (3) I understand that any incorrect statements may result in my coverage or my dependents' coverage being terminated, rescinded and/or claims not paid; (4) I have read this form; (5) I authorize GEGGLAC to verify all information.

I hereby authorize any health care practitioner, health care facility, the Medical Information Bureau or similar organization, any employer, group policyholder or certificateholder to disclose or furnish to GE Group Life Assurance Company (GEGGLAC) and its legal representatives, any and all information with respect to my employment and the physical or mental health of me or my dependents. I understand that the information released to GEGGLAC will be used to determine eligibility for the insurance requested. GEGGLAC may redisclose such information for that purpose to the employer or union sponsoring the group insurance coverage, the group policyholder or certificate holder, or their legal representatives, to any reinsurer, and to any person or entity performing a business or legal function for the benefit of GEGGLAC. The information may also be redisclosed as otherwise specifically permitted or required by law. The information will not be given, sold or transferred to any other person or entity.

This authorization extends to records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS) or information relating to alcohol or drug abuse or mental health care to the extent permitted by law.

This authorization is valid for up to 24 months from the date it was signed. I understand that I have the right to revoke this authorization at any time by writing to GEGGLAC at the address listed at the top of this form. Revocation of this authorization will not affect the rights of anyone who acted in reasonable reliance on the authorization before receiving notice of the revocation. Revocation of or failure to sign this authorization may impair GEGGLAC's ability to evaluate an application and may result in a denial of coverage. A photocopy of this authorization shall be as valid as the original. I understand that I am entitled to a photocopy of this authorization upon request.

Signature of Employee

Date

