

**HOW TO COMPLETE YOUR ENROLLMENT REQUEST**  
Please be sure to complete all information on this card



## Enrollment Request Voluntary Dental and Disability Plans

GE Group Life Assurance Company  
Attn: Group Eligibility

Add     Change     Termination     Correction  
Date: \_\_\_\_\_ Reason: \_\_\_\_\_

**EMPLOYER INFORMATION SECTION  
MUST BE COMPLETED BY  
EMPLOYER**

- Legal Name of Employer.

**Employer Information - to be completed by Employer**

1. Group Account Number \_\_\_\_\_ 2. Other Group Account Number(s) \_\_\_\_\_ 3. Class \_\_\_\_\_

4. Name of Employer \_\_\_\_\_

5. Employer's Address (Number, Street, City, State, ZIP Code) \_\_\_\_\_

**EMPLOYEE SECTION**

Must be completed by employee to determine eligibility.

- Occupation / Title must coincide with those listed on your Application(s) / Insurance Benefit(s).

**Employee Information - to be completed by Employee**

6. Name of Employee (Last, First, M.I.) \_\_\_\_\_ 7. Social Security Number \_\_\_\_\_

8. Employee's Address (Number, Street, City, State, ZIP Code) \_\_\_\_\_ 9. Employee's Home Phone No. \_\_\_\_\_

10. Sex  Male  Female    11. Date of Birth (Mo., Day, Yr.) \_\_\_\_\_

12. Marital Status  Single  Married    13. My employment is covered under Union Collective Bargaining  Yes

14. Hours worked weekly for this employer  Active  Retired  COBRA    15. Date Employed (Mo., Day, Yr.)  Full-Time  Part-time  Rehire  Return from Layoff

16. Basic Earnings \$ \_\_\_\_\_  Hourly \_\_\_\_\_ Hrs/Wk \_\_\_\_\_  Monthly  Weekly  Annually    17. Employee's Occupation (Title) \_\_\_\_\_

NOTE: If you refuse Dental benefits for yourself, you automatically refuse these benefits for any dependents. If you refuse any benefit now, and later request to add that benefit, your coverage may be limited as outlined in the certificate. Some or all of these benefits may be funded by your employer. THOSE BENEFITS COMPLETELY PAID FOR BY THE EMPLOYER CANNOT BE REFUSED. All benefits may not be available; check with your plan administrator. Indicate your choice by checking the appropriate box.

- Check off your election or refusal to participate in the applicable coverage.

**Group Benefits Requested - to be completed by Employee**

**Dental**  
Plan Election (if applicable)  Plan I     Plan II

Employee  I elect     I refuse  
Dependents  I elect     I refuse    Amount deducted per pay period \$ \_\_\_\_\_

**Disability**  
Select a weekly benefit amount not to exceed more than 60% of your basic weekly earnings.

\$100     \$150     \$200     \$250     \$300     \$350  
 \$400     \$450     \$500     Other \$ \_\_\_\_\_     I refuse

Amount deducted per pay period \$ \_\_\_\_\_     Pre-tax     After-tax

- Complete this section if you are applying for Dental.

- Children between age 19-25 must be full-time students at an accredited college or university.

**Please complete this entire section if you are selecting Dental Coverage.**

Last Name	First Name	M.I.	Date of Birth	Sex	Social Security Number
Employee					/ /
Spouse					/ /
Child					/ /
Child					/ /
Child					/ /

**Student Verification - Please complete the following if any child listed is a full-time college student.**

Name of child: \_\_\_\_\_ School Name and Address: \_\_\_\_\_

Course of Study: \_\_\_\_\_ Semester: \_\_\_\_\_ Anticipated date of graduation (month/year): \_\_\_\_\_

Full signature (must be in ink) of employee is required and must be dated.

I request benefits under the group coverage issued by GE Group Life Assurance Company and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply, or as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct and that this request is subject to the representations made on the reverse side of this request which I have read and fully understand. I understand and agree that any incorrect statements material to the risk made by me in this enrollment request may invalidate my benefit(s) and result in claim denials and that all statements made by me shall be deemed representations and not warranties.

I understand the coverage made available to me and I wish to enroll (or decline to enroll) in this coverage as indicated above. I understand that if I do not enroll in this coverage now, but later decide to enroll, I must wait until the next designated open enrollment period.

To the best of my knowledge I am an employee working the weekly hours shown above at the employer's regular place of business, and I agree any information shown above including the refusal section is correct and my signing below indicates that I understand all information given is subject to verification.

I agree that my Employer acts as my agent in all dealings with the Plan(s), and that all notices given to him are binding upon me. I also agree that my participation in the benefit(s) and the authorization and agreements stipulated herein are subject to any future amendments to the Plan(s).

I certify that I have read the reverse side of this form.

Date \_\_\_\_\_ Signature \_\_\_\_\_



# Enrollment Request Voluntary Dental and Disability Plans

GE Group Life Assurance Company  
Attn: Group Eligibility

Add     Change     Termination     Correction  
Date: \_\_\_\_\_ Reason: \_\_\_\_\_

### Employer Information - to be completed by Employer

1. Group Account Number	2. Other Group Account Number(s)	3. Class
4. Name of Employer		
5. Employer's Address (Number, Street, City, State, ZIP Code)		

### Employee Information - to be completed by Employee

6. Name of Employee (Last, First, M.I.)		7. Social Security Number	
8. Employee's Address (Number, Street, City, State, ZIP Code)		9. Employee's Home Phone No.	
10. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	11. Date of Birth (Mo., Day, Yr.)	12. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married	13. My employment is covered under Union Collective Bargaining <input type="checkbox"/> Yes
14. Hours worked weekly for this employer <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA (Excluding Overtime)	15. Date Employed (Mo., Day, Yr.) <input type="checkbox"/> Full-Time ____/____/____ <input type="checkbox"/> Part-time ____/____/____ <input type="checkbox"/> Rehire ____/____/____ <input type="checkbox"/> Return from Layoff ____/____/____		
16. Basic Earnings <input type="checkbox"/> Hourly _____ Hrs/Wk \$ _____ <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually	17. Employee's Occupation (Title)		

NOTE: If you refuse Dental benefits for yourself, you automatically refuse these benefits for any dependents. If you refuse any benefit now, and later request to add that benefit, your coverage may be limited as outlined in the certificate. Some or all of these benefits may be funded by your employer. THOSE BENEFITS COMPLETELY PAID FOR BY THE EMPLOYER CANNOT BE REFUSED. All benefits may not be available; check with your plan administrator. Indicate your choice by checking the appropriate box.

### Group Benefits Requested - to be completed by Employee

#### Dental

Plan Election (if applicable)  Plan I    Plan II  
Employee    I elect    I refuse  
Dependents    I elect    I refuse   Amount deducted per pay period \$ \_\_\_\_\_

#### Disability

Select a weekly benefit amount not to exceed 60% of your basic weekly earnings.  
 \$100    \$150    \$200    \$250    \$300    \$350  
 \$400    \$450    \$500    Other \$ \_\_\_\_\_    I refuse  
Amount deducted per pay period \$ \_\_\_\_\_    Pre-tax    After-tax

### Please complete this *entire* section if you are selecting Dental Coverage.

Last Name	First Name	M.I.	Date of Birth	Sex	Social Security Number
Employee					/ /
Spouse					/ /
Child					/ /
Child					/ /
Child					/ /

### Student Verification - Please complete the following if any child listed is a full-time college student.

Name of child: \_\_\_\_\_ School Name and Address: \_\_\_\_\_  
Course of Study: \_\_\_\_\_ Semester: \_\_\_\_\_ Anticipated date of graduation (month/year): \_\_\_\_\_

I request benefits under the group coverage issued by GE Group Life Assurance Company and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply, or as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct and that this request is subject to the representations made on the reverse side of this request which I have read and fully understand. I understand and agree that any incorrect statements material to the risk made by me in this enrollment request may invalidate my benefit(s) and result in claim denials and that all statements made by me shall be deemed representations and not warranties.

I understand the coverage made available to me and I wish to enroll (or decline to enroll) in this coverage as indicated above. I understand that if I do not enroll in this coverage now, but later decide to enroll, I must wait until the next designated open enrollment period.

To the best of my knowledge I am an employee working the weekly hours shown above at the employer's regular place of business, and I agree any information shown above including the **refusal section** is correct and my signing below indicates that I understand all information given is subject to verification.

I agree that my Employer acts as my agent in all dealings with the Plan(s), and that all notices given to him are binding upon me. I also agree that my participation in the benefit(s) and the authorization and agreements stipulated herein are subject to any future amendments to the Plan(s).

I certify that I have read the reverse side of this form.

Date	Signature
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Any person who knowingly and with intent to defraud any insurance company or other person either: 1) files an application for insurance or statement of claim containing any materially false information, or 2) conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime. VIOLATIONS ARE SUBJECT TO CRIMINAL PROSECUTION AND MAY ALSO RESULT IN SUBSTANTIAL CIVIL PENALTIES.

In Florida, any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

In Virginia the above statements do not apply.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health coverage.

In Louisiana, any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.