JEFFERSON PILOT FINANCIAL

Jefferson Pilot Financial Insurance Company
P.O. Box 2616, Omaha NE 68103-2616
Phone (800) 423-2765 or (402) 361-7300
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ENROLLMENT FORM FOR GROUP INSURANCE

OFFICE CODE:	Memo

Please Use Ink or Type

GROUP ID:	GROUP POLICY #:

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print)		County	State
Social Security Number	Last Name / First Name / MI		
Street Address / City / State / Zip			Date of Birth
☐ Male ☐ Female	Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed	Spouses Date of Birth	Home Phone ( ) / Work Phone ( )

Completed By Employer

Effective Date:	Date of Full-Time Employment:	Occupation:
Earnings: $________ ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly	☐ Union ☐ Exempt ☐ Non-Union ☐ Non-Exempt	Average Hours Worked Per Week: / Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

NOTE: Please mark each box if you are eligible for the listed coverage.

Class	Effective Date	Basic Amount *Employer to Complete*	Coverage			Amount	Dental
			Group Life	☐ Yes	☐ No		☐ Single Dental
			Group AD&D	☐ Yes	☐ No		☐ EE/Spouse
			Dependent Life	☐ Yes	☐ No		☐ EE/Spouse/Children
			Optional Employee Life	☐ Yes	☐ No		☐ EE/Children ☐ One Child
			Optional Dependent Life	☐ Yes	☐ No		☐ 2 or More Children ☐ No Coverage
			Optional AD&D	☐ Yes	☐ No		
			Long Term Disability	☐ Yes	☐ No		Effective:________
			Short Term Disability	☐ Yes	☐ No		

C. Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)

Primary Beneficiary's Last Name / First / MI	Relationship of Beneficiary	Social Security Number
Street Address / City	State	Zip
Contingent Beneficiary's Last Name / First / MI	Relationship of Beneficiary	Social Security Number
Street Address / City	State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

D. Signature (Complete for ALL Enrollments)

I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. I reserve the right to revoke this deduction at any time on written notice.

______________________________ Employee Signature

______________ Date Signed

Dental Enrollment is on the back of this Enrollment Form.