Enrollment Form

for group term life, voluntary life and/or disability coverage

ADVANCE Insurance Company of Kansas SM

Instructions: Attach form AICK 4EV 12/19 if a Late Enrollee or requesting more than the Guarantee Issue amount.

Employer Name _____ AICK Group Number _____

Section 1 – Employee and Employment Information

CLEAR DATA

First Name _____ MI _____

Last Name _____ Suffix _____

Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____

Gender ☐ Male ☐ Female

Date of Birth _____ /_____ /_____

Social Security Number _____-_____-_____

Home/Cell Phone Number (_____) _____-_____

Are you married? ☐ Yes ☐ No

Do you have unmarried dependent children under 23 years of age? ☐ Yes ☐ No

Occupation/Job Title _____

Work Phone Number (_____) _____-_____

Date of Hire _____ /_____ /_____

Are you actively at work performing all of your job duties? ☐ Yes ☐ No

I am working _____ hours weekly for this employer.

$_____ ☐ HR ☐ WK ☐ MO ☐ ANN

Base Earning Wage

Base earnings do not include commission, bonuses, overtime or any other extra compensation except as shown in the group policy.

Check one option below:

☐ I am a new employee enrolling at my first opportunity.

☐ I am a rehired employee as of _____ /_____ /_____

☐ I am an existing employee enrolling due to:

- ☐ Temporary to permanent status
- ☐ Other (specify) _____

_____ /_____ /_____

Date of Employment Change

I am enrolling in:

Basic term life and AD&D	☐ Yes	☐ No
Voluntary life	☐ Yes	☐ No
Dependent life	☐ Yes	☐ No
Short term disability	☐ Yes	☐ No
Long term disability	☐ Yes	☐ No

Section 1a – Spouse Information (complete if enrolling your spouse in voluntary life coverage)

First Name _____ MI _____

Last Name _____ Suffix _____

Gender ☐ Male ☐ Female

Social Security Number _____-_____-_____

Date of Birth _____ /_____ /_____

Date of Marriage _____ /_____ /_____

Section 2 – Coverage Election for Voluntary Life Insurance (Employee Paid)

I am electing the following coverage: (check all that apply) ☐ Employee ☐ Spouse ☐ Child

Employee or spouse: Minimum is $10,000.

Coverage amounts above the minimum may be selected in $1,000 increments up to the maximum group benefit amount. What is the amount of the Voluntary Term Life coverage being requested?

$_____ Employee Coverage Amount

$_____ Spouse Coverage Amount

Please continue on the next page.

Section 2 – Coverage Election for Voluntary Life Insurance (Employee Paid) – continued

Dependent child: With approval of at least $10,000 of coverage for you or your spouse, this coverage may be requested. All eligible unmarried dependent children from age 6 months to 23 years will receive the benefit amount selected below; and from age 15 days to 6 months will receive 10% of the selected benefit.

Select only one amount for all dependent children:
☐ $5,000 ☐ $10,000

Section 3 – Your (The Employee's) Primary Beneficiary

Primary Beneficiary receives the benefit upon death of the insured. If naming two or more Primary Beneficiaries, the proceeds will be paid in equal shares unless stated otherwise. If you need more space, attach a separate sheet with complete information. **You must sign and date the separate sheet.**

Last Name _____ Suffix _____ First Name _____ MI _____

Relationship to Applicant _____ Date of Birth ____/____/____ or Age _____

Last Name _____ Suffix _____ First Name _____ MI _____

Relationship to Applicant _____ Date of Birth ____/____/____ or Age _____

Section 3a – Your (The Employee's) Contingent Beneficiary

Contingent Beneficiary receives the benefit only if the primary beneficiary(ies) listed in the previous section is/are deceased. If you need more space, attach a separate sheet with complete information. **You must sign and date the separate sheet.**

Last Name _____ Suffix _____ First Name _____ MI _____

Relationship to Applicant _____ Date of Birth ____/____/____ or Age _____

Last Name _____ Suffix _____ First Name _____ MI _____

Relationship to Applicant _____ Date of Birth ____/____/____ or Age _____

Section 3b – Spouse or Child Beneficiary (when your spouse or child has this coverage)

You (the employee) will be your spouse's beneficiary in the event of a payment of a death benefit for your spouse. If your spouse wants to name someone else (other than you) as their beneficiary, your spouse should attach a separate sheet with complete information. Your spouse must sign and date the separate sheet.

You (the employee) will be the beneficiary in the event of a payment of a death benefit for a dependent child.

Section 4 – Authorization

I understand that if I am not at work on the effective date of this coverage, this coverage will not begin until the day I return to active work. I understand that to be insured that I must be actively at work 1) performing all the normal duties of my job, 2) at the usual place, 3) for the required hours each week as stated in the group policy. I authorize the necessary payroll deductions from my earnings and designate the beneficiary(ies) named on this form to receive the benefit payable in the event of death. I believe that all persons for whom I am requesting coverage are resident citizens of the U.S.A. or are aliens legally residing in the U.S.A.; and that the information which I have provided on this form is true and correct as it pertains to my status with the named employer.

Your signature required _____ Employee Signature ____/____/____ Date Signed