



**ENROLLMENT FORM FOR GROUP INSURANCE**

OFFICE CODE:	Mem
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Please Use Ink or Type    GROUP ID: **MIAMICOLLE**    GROUP POLICY #:

**A. Employee Information (Complete for ALL Enrollments)**

Employer Name/Company Name <b>MIAMI DADE COLLEGE</b>		Division	State <b>FL</b>
Employee Social Security Number	Employee Last Name	First Name	MI
Gender	Employee Date of Birth		

**Employee Work Information (Complete for ALL Enrollments)**

Effective Date:	Date of Full-Time Employment/Rehire:	Average Hours Worked Per Week:
Earnings:	<input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Yearly	Occupation:

**B. Product Selection (Complete for ALL Enrollments)**

Class	Coverage	Selecting Yes to voluntary coverages authorizes my employer to payroll deduct premium(s)	Approximate Benefit Amount Approximate Monthly Cost
	<b>Life / AD&amp;D</b>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	One x Salary Up To A \$400,000 Maximum Employer Paid
	<b>Optional Employee Life / AD&amp;D</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No*	One x Salary Up To A \$400,000 Maximum
	<b>Optional Dependent Life</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No*	Covers Spouse or Domestic Partner and Children (see benefit summary for details)

**C. Beneficiary Information**

**PRIMARY BENEFICIARY** – If you wish to split your benefit between more than 2 people please attach a separate piece of paper.

Name	Relationship of Beneficiary	Social Security Number <small>Non family members only</small>	Address <small>(List per beneficiary only if different)</small>	% of benefit
1.				
2.				

**CONTINGENT BENEFICIARY** - will receive benefits only if the Primary Beneficiary does not survive you

1.				
2.				

\*By selecting no, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense  
-- Actual deductions may vary slightly from above illustration due to rounding --

**NOTICE:** ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER, FILES A STATEMENT OF CLAIM OR APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

The insurance requested on this enrollment form will not be effective until approved by the Home Office of Jefferson Pilot Financial Insurance Company, and the initial premium is paid to Jefferson Pilot Financial Insurance Company. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_