EMPLOYEE ENROLLMENT FORM

OPTIONAL LIFE COVERAGE

ADVANCE* Insurance Company of Kansas

www.advanceinsurance.com

Applying for:

☒ $25,000 $15.50 monthly

Section A — Always complete this section.

Employee name _____ (Last / First / MI) Employee Social Security no. _____

Employee date of birth _____ Gender: ☐ Male ☐ Female ☐ Single ☐ Married ☐ Legally separated

If married, spouse name _____ (Last / First / MI) Spouse Social Security no. _____

Spouse date of birth _____ (Month / Day / Year) Gender: ☐ Male ☐ Female Does the firm shown below employ your spouse? ☐ Yes ☐ No

Home address _____ (Street / City / State / Zip code) Home phone _____

Hourly wage $_____ Full-time employment date _____ (Month / Day / Year) Rehire date _____ (Month / Day / Year)

Occupation/job title _____ Work phone _____

I am actively at work performing all of my job duties. ☒ Yes ☐ No I work _____ hours each week for this employer.

Section B— Beneficiary Designation

The Beneficiary of your Optional Life Insurance will be the same as the beneficiary of your basic term life unless you notify us otherwise, **in writing**.

Section C — Authorization and Acceptance

I hereby request to be insured for the insurance coverage for which I may become eligible under the group policy issued by AICK to my employer. I hereby authorize the policyholder to make necessary payroll deductions from my paycheck if any are required. I am a resident citizen of the U.S.A. or an alien legally residing in the U.S.A., and, to the best of my knowledge, the information that I have provided on this form is true and correct as it pertains to my status with the above employer.

Employee Sign Here X _____ Date Signed _____

Section D — Non-acceptance. Complete this section only if you DO NOT WISH TO ENROLL

The group insurance program has been offered to me and after seriously considering its benefits, I have decided not to enroll.

Reason: _____

I understand that if I do not enroll when first eligible and choose to participate in the insurance program at some future date evidence of insurability may be required, perhaps to include passing a thorough physical by the applicant(s) at my own expense, and that coverage may be declined.

Employee Sign Here X _____ Date Signed _____

Policyholder (Employer) X _____