**American General**
Life Companies

# Group Employee Enrollment Form

## American General Life Insurance Company of Delaware*
Wilmington, Delaware

Print

Administrative Office: PO Box 30066, Tampa, FL 33630-3066
Phone: 1-877-672-1648, Fax: 1-877-672-1650

*This company does not solicit business in New York.

| Completing Your **GROUP ENROLLMENT FORM**<br>1. **Fully complete** each section<br>2. **Sign and date** Refusal/Authorization Section, as needed. | Group Policy No.(s)<br>07108I | ☒ **NEW ENROLLMENT**<br>☐ **CHANGE IN ENROLLMENT** |
|---|---|---|

**1. PERSONAL DATA: (Must always be completed)**

| Billing Location | Class | Social Security No. | Last Name | First Name | Initial |
|---|---|---|---|---|---|
| | | | | | |

| Sex ☐ Male ☐ Female | Date of Birth MM DD YY | Street Address | City | State | Zip Code |
|---|---|---|---|---|---|
| | | | | | |

| Name of Employer GTN Technical Staffing | Location 14800 Quorum Suite 150, Dallas, TX | Salary $ _____ Per _____ |
|---|---|---|

| Occupation | Title | Date of Full-Time Employment MM DD YY | No. Hours Worked Per Week 40 ☐ Union ☐ NonUnion |
|---|---|---|---|
| | | | |

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced | Dependent Children No ☐ Yes ☐ If Yes, # _____

**2. ENROLLMENT**

If enrolling for Dental or Vision benefits, list name, relationship to you, and date of birth for each dependent to be insured. PLEASE LIST ADDITIONAL DEPENDENTS ON A SEPARATE SHEET.

Give policy number, name and address of current employer's prior group insurance carrier, if you and your dependents were insured. Indicate your effective and termination dates of coverage also.

If high/low dental, please select one.

| Name | Relationship Self | Sp. | Ch. | Date of Birth MM/DD/YY | Sex |
|---|---|---|---|---|---|
| SELF | X | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

☐ High
☐ Low

**3. Supplemental Life Benefit: If this benefit is a plan option and you wish to enroll for Supplemental Life coverage, please indicate**

**Life Amount for: Employee $** _____ **Spouse $** _____ **Dependent $** _____

**4. Supplemental AD&D Benefit: If this benefit is a plan option and you wish to enroll for Supplemental AD&D coverage, please indicate**

**AD&D Amount for: Employee $** _____

**5. Beneficiary Designation: as is**

| EX: MARY A. JONES, WIFE<br>NOT MRS. JOHN JONES | First Name | Initial | Last Name | Relationship |
|---|---|---|---|---|
| | | | | |

**6. REFUSAL OF COVERAGE: (Note: Benefits provided on a non-contributory basis cannot be refused)**

I was given the opportunity to enroll in this plan for group insurance offered by my employer/association and insured by AG Life Insurance Co. of DE.

**I am refusing:**

- ☐ LTD
- ☐ STD
- ☐ Life/AD&D
- ☐ Dependent Life
- ☐ All coverages offered

**Dental:**

- ☐ Employee & Dependents
- ☐ Spouse
- ☐ Child(ren)
- ☐ All Dependents

**Vision:**

- ☐ Employee & Dependents
- ☐ Spouse
- ☐ Child(ren)
- ☐ All Dependents

**MUST ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD COVERAGE:**

Are you or your dependents now covered by any other group plan? ☐ YES ☐ NO (Your dependent(s) may be insured by this Plan even if they are insured elsewhere)

If Yes: Policyholder's Name _____ Carrier _____

I understand that if I am refusing insurance because I am insured under another applicable insurance plan, I may be added to this plan under the same terms and conditions with respect to pre-existing conditions and their limitations as if I enrolled when initially eligible. I understand that I must request enrollment within 31 days following the termination of the other applicable insurance plan.

If Dental coverage is refused, I understand that my benefits may be reduced if I later wish to enroll for this coverage.
I must furnish, at my expense, **evidence of insurability** satisfactory to AG Life Insurance Co. of DE if I later wish to enroll in any other coverage that is now being refused.

_____ _____
*DATE OF REFUSAL* *SIGNATURE IF REFUSING ANY COVERAGE*

***IF REFUSING ALL COVERAGES, IT IS NOT NECESSARY TO COMPLETE THE REMAINDER OF THIS FORM.**

**7. AUTHORIZATION:**

- I hereby certify that all information furnished is true to the best of my knowledge.
- I request group insurance for which I am or may become eligible.
- If I am required to contribute to the premium for any coverage elected on this form, I hereby authorize my employer to deduct such contributions in advance from wages due me, for remittance to AG Life Insurance Co. of DE
- I designate the beneficiary named on this form to receive the proceeds, if any, payable upon my death.
- If dental care or health care is provided by a participating provider, all benefits will be paid directly to the provider by AG Life Insurance Co. of DE.
- I authorize any insurer or employer or any consumer reporting agency acting on its behalf to give to AG Life Insurance Co. of DE information about me. Such information will pertain to my employment or other insurance coverage.

_____ _____
*DATE SIGNED* *APPLICANT'S SIGNATURE*

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