

Enrollment and Change

To Be Completed By Human Resources

Group Number 448468	Division Members other than Chief Officer, Project Manager, or Supervisory employees	Billing Category	Date of Employment
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To Be Completed By Applicant

- Apply for Coverage Name Change Former Name _____
 Add Dependent Delete Dependent Date of Add/Delete _____
 Reinstatement

Your Full Name	Social Security Number	Birth Date	
Address	City	State	ZIP
Phone Number	Job Title/Occupation	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Employer Name R-J Taylor, General Contractors, Inc	Hours Worked Per Week	Are You Actively At Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year			
Have you used tobacco in any form in the last 12 months? You: <input type="checkbox"/> Yes <input type="checkbox"/> No			
Spouse Full Name			Birth Date

Coverage

Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, Evidence Of Insurability requirements.

Life Insurance
<input type="checkbox"/> Life with AD&D (Employee Paid) requested amount \$ _____

Dependents Life Insurance
<input type="checkbox"/> Spouse Life with AD&D (Employee Paid) requested amount \$ _____
<input type="checkbox"/> Child(ren) Life with AD&D (Employee Paid) requested amount \$ _____

Your Full Name

Specified Disease Insurance

A. Do you or your Spouse (if applying for Spouse coverage) have any other specified disease policies or certificates pending or in-force for the same specified disease(s) that will not be replaced by this policy? If "yes", specified disease insurance is not available. Yes No

B. Will purchase of this policy result in you or your Spouse (if applying for Spouse coverage) being covered for more than 7 specified diseases, because of an additional specified disease policy that is not being replaced by this policy? If "yes", specified disease insurance is not available. Yes No

(NOTE: This Specified Disease Insurance Policy covers the following specified diseases: (1) Alzheimer's Disease; (2) End-Stage Renal (Kidney) Failure; (3) Major Organ Failure; (4) Myocardial Infarction (Heart Attack); (5) Severe Coronary Artery Disease; (6) Stroke; (7) Cancer.)

C. When the coverage goes into effect, will you and your Spouse (if applying for Spouse coverage) have either (a) major medical insurance or (b) basic hospital and basic medical insurance? If the answer to this question is "no", the specified disease insurance will not be issued. Yes No

Specified Disease Insurance (Employee Paid)*
 Employee* requested amount \$10,000 \$20,000
 Spouse requested amount \$5,000 \$10,000
 *Eligible child(ren) are automatically covered at 50% of your Coverage Amount.

Beneficiary

This designation applies to your Life and Accidental Death and Dismemberment Insurance, if any, available through your Employer. Unless specified otherwise on a separate sheet of paper, this designation also will apply to your Supplemental Life and Accident Insurance, if any, available through your Employer, unless replaced by a separate and later designation. Designations are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.

Primary — Full Name	Address	DOB	Phone No.	SSN if known	Relationship	% of Benefit*
Contingent — Full Name	Address	DOB	Phone No.	SSN if known	Relationship	% of Benefit*

*Total must equal 100%

For Specified Disease Insurance:
 The coverage applied for provides limited benefits health insurance only. This coverage does not meet the minimum requirements for Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance in the state of New York. Purchase of this coverage may be unnecessary if you already have or intend to purchase Medicare supplement insurance or long term care insurance.