Check One - Employer Use
- o New Employee
  Date of Hire ________
- o Change
- o Open Enrollment

Protective
Protective Life Insurance Company

GROUP INSURANCE ENROLLMENT CARD

(Please print clearly)

EMPLOYER:	LOCATION/DIVISION:

EMPLOYEE NAME: (First) (M.I.) (Last)

ADDRESS CITY ST ZIP

SOCIAL SECURITY NUMBER BIRTHDATE PHONE SEX: o Male o Female

DENTAL COVERAGE

I APPLY FOR:
- o EMPLOYEE ONLY
- o EMPLOYEE & ELIGIBLE DEPENDENTS

o I DECLINE COVERAGE FOR:
- o EMPLOYEE
- o SPOUSE
- o CHILD(REN)

DO YOU HAVE ELIGIBLE DEPENDENTS? o YES o NO. IF YES, COMPLETE BELOW TO ENROLL THEM	RELATION	SEX	BIRTHDATE		
			MO	DAY	YR
Spouse					
Child(ren)					

- o List additional Children on Reverse Side and check box.
- If the address of any child is different than the employee's address, please show that child's name and address below.
  ____
- If requesting coverage for a dependent child other than a son or daughter, please forward legal custody papers.

To the best of my knowledge and belief, each of the statements and answers supplied in this form is complete and true, and they constitute the sole basis for, and are the inducement for, the issuance of any insurance.

I hereby apply as indicated herein for the insurance for which I am not now insured and for which I am or may become eligible under the terms of Protective Life Insurance Company's group policy or policies (including any future amendments) applying to, or requested to apply to, the employer named above. If such insurance becomes effective, I authorize deductions from my earnings of my contributions required from time to time toward the cost of such insurance. I represent that I am an active full-time employee of that employer.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

Date: _____/_____/_____ Employee's Signature: ______________________________

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