Section A: Employer Information *Please type or print clearly in black or blue ink*

1. **Employer/Group Name:**			2. **Life Group No: 16150**
3. Coverage Effective Date:	4. Date of Hire:	5. Occupation:	6.Soc Sec# ☐☐☐-☐☐-☐☐☐☐

Section B: Employee Information *(Note: If additional space is needed, please print on separate sheet, sign and date)*

7. Last Name:		First Name:		M.I.
8. Date of Birth: ☐☐-☐☐-☐☐☐☐	9. Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated		10. Gender: ☐ Female ☐ Male	
11. Mailing Address:	12. Apt #:	13. City:	14. State	15. Zip:
16. County:	17. Home Phone with Area Code:	18. Work Phone:	19. Cell Phone:	

Section C: Coverage Requested

20. Basic Term Life	21. Accidental Death and Dismemberment (AD&D)	22. Dependent Life
☒ $15,000	☒ $30,000	☒ $5,000 (Spouse) ☒ $2,500 (Child)

23. ☐ I am refusing all Life Coverage at this time. I understand that if I decide to apply later, there may be additional requirements.

Signature:____ Date: ______________________

Section D: Group Life Beneficiary Information *Attach separate sheet if additional space is needed for beneficiary information, sign & date.*

25. Last Name, First Name, MI	Date of Birth	Relation to You			% of Share
		(S) Spouse	(C) Child	(O)* Other	Total % must = 100%
Primary					
Primary					
Primary					
Secondary (Contingent)					
Secondary (Contingent)					

*If you indicated "O" in "Relation to You" above for any beneficiaries, please explain here:

Section E: Acceptance of Life Coverage

27. **Request for Signature and Certification:** I wish to apply for the coverage selected in section **C** as outlined above. I have read and understand the acceptance of coverage on this form. I certify the statements on this application, including any attachment to it, are true and complete to the best of my knowledge and belief.

28. Signature:	29. Date:

FRAUD NOTICE: I understand that any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim of an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Section F: Acceptance of Coverage Authorization

I hereby apply for the coverage selected on the front of this form. My employer has selected the coverage through Florida Combined Life Insurance Company, Inc. (FCL). I authorize my employer to deduct from my earnings my premium contribution (if any). I understand all of the following: 1) if my coverage is issued and continued, I must meet all the group contract's requirements; 2) if my dependents' coverage, if any, is to be issued and continued, my dependents must meet all the group contract's requirements; 3) if I am not actively at work on my proposed coverage effective date, my effective date for certain coverages **may** be deferred until the date I return to active work.
I understand a dependent cannot be: 1) covered as both a dependent and an employee, including married employees of the same employer; 2) covered under more than one employee; 3) full-time military.
I understand that my employer is not an agent of FCL. I also understand that my employer is responsible for notifying all employees of 1) all effective dates; 2) all termination dates; 3) any Employee Retirement Income Security Act (ERISA) rights or responsibilities; 4) all other matters pertaining to coverage under the group contract.
I acknowledge that FCL coverage is contingent upon the complete, accurate disclosure of the information requested. I hereby certify that the statements in this application, including any attachment to it, are true and complete to the best of my knowledge and belief. I understand and agree that any misrepresentations, omissions, concealments of facts, or incorrect statements may result in denial of benefits and/or termination of coverage.
A photocopy of this application shall be as valid as the original. However, the original application is required to evaluate this application. I agree to be bound by the group contract's terms and conditions. I understand that this application is hereby made a part of the group contract. I will attach it to my certificate of coverage when issued.