


HOW TO COMPLETE YOUR ENROLLMENT REQUEST
Please be sure to complete all information on this card



Enrollment Request

GE Group Life Assurance Company
Attn: Group Eligibility

Add Change Termination Correction
 Date: _____ Reason: _____

Employer Information - to be completed by Employer

| | | |
|---|----------------------------------|----------|
| 1. Group Account Number | 2. Other Group Account Number(s) | 3. Class |
| 4. Name of Employer | | |
| 5. Employer's Address (Number, Street, City, State, ZIP Code) | | |

Employee Information - to be completed by Employee

| | | |
|--|---|--|
| 6. Name of Employee (Last, First, M.I.) | | 7. Social Security Number |
| 8. Employee's Address (Number, Street, City, State, ZIP Code) | | 9. Employee's Home Phone No. |
| 10. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | 11. Date of Birth (Mo., Day, Yr.) | 12. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married |
| 13. My employment is covered under Union Collective Bargaining <input type="checkbox"/> Yes <input type="checkbox"/> No | 14. Hours worked weekly for this employer (Excluding Overtime) <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA | 15. Date Employed (Mo., Day, Yr.) <input type="checkbox"/> Full-Time <input type="checkbox"/> Part-time <input type="checkbox"/> Rehire <input type="checkbox"/> Return from Layoff |
| 16. Basic Earnings \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually | 17. Employee's Occupation (Title) | |

NOTE: If you refuse Medical or Dental benefits for yourself, you automatically refuse these benefits for any dependents. If you refuse any benefit now, and later request to add that benefit, your coverage may be limited as outlined in the certificate. Some or all of these benefits may be funded by your employer. Administrative Services and forms provided by GE Group Administrators, Inc. does not imply liability for GEGA for claim payment. See your employer for details. THOSE BENEFITS COMPLETELY PAID FOR BY THE EMPLOYER CANNOT BE REFUSED. All benefits may not be available; check with your plan administrator. Indicate your choice by checking the appropriate box.

Group Benefits Requested - to be completed by Employee

| | | |
|--|---|--|
| Life/AD&D <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse | Dependent Life/AD&D <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse | Supplemental Life/AD&D <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse |
| Dental <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse | Dependent Dental <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse | Medical <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse |
| Dependent Dental <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse | Dependent Medical <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse | Long Term Disability <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse |

*If you have refused Medical or Dental, is it because you have other Group Coverage? Medical Yes No Dental Yes No
 **If you have refused Medical or Dental for your dependents, is it because they have other Group Coverage? Medical Yes No Dental Yes No

Please Complete The Following Question If You Are Electing Medical Coverage

Did you or your dependent have prior medical coverage? Yes No If so, Single Family Dependent(s)
 Individual Policy Group Policy HMO Other _____
 Name of Carrier _____ Termination date of Coverage ____/____/____
 Reason for Termination _____

Please complete this entire section if you are selecting Medical and/or Dental Coverage.

| Last Name | First Name | M.I. | Date of Birth | Sex | Social Security Number |
|-----------|------------|------|---------------|-----|------------------------|
| Employee | | | | | / / |
| Spouse | | | | | / / |
| Child | | | | | / / |
| Child | | | | | / / |
| Child | | | | | / / |

Student Verification - Please complete the following if any child listed is a full-time college student.

Name of child: _____ School Name and Address: _____
 Course of Study: _____ Semester: _____ Anticipated date of graduation (month/year): _____

Beneficiary Designation - applies ONLY if life insurance is being elected at this time

| | | | |
|----------------------------|-----------------------------|--------------|---------|
| 22. Primary - Last Name | First Name & Middle Initial | Relationship | Address |
| 23. Contingent - Last Name | First Name & Middle Initial | Relationship | Address |

NOTE: You may designate a new beneficiary at any time, subject to the conditions and provisions of the Group Policy.

I request benefits under the group coverage issued by GE Group Life Assurance Company and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply, or as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct and that this request is subject to the representations made on the reverse side of this request which I have read and fully understand. I understand and agree that any incorrect statements material to the risk made by me in this enrollment request may invalidate my benefit(s) and result in claim denials and that all statements made by me shall be deemed representations and not warranties.

I designate the beneficiary(ies) shown above to receive all sums which may become due on account of my death under this group coverage. I understand that proceeds will be payable in equal shares to those primary beneficiaries who survive me but if no primary beneficiary survives such proceeds will instead be payable in equal shares to those contingent beneficiaries who survive me.

To the best of my knowledge I am an employee working the weekly hours shown above at the employer's regular place of business, and I agree any information shown above including the refusal section is correct and my signing below indicates that I understand all information given is subject to verification.

I agree that my Employer acts as my agent in all dealings with the Plan(s), and that all notices given to him are binding upon me. I also agree that my participation in the benefit(s) and the authorization and agreements stipulated herein are subject to any future amendments to the Plan(s).

I certify that I have read the reverse side of this form.

24. Date

25. Signature

ESG-GL2479 (05/01) 1st copy - GEFA, 2nd copy - GEGA, 3rd copy - Employer, 4th copy - Employee/Subscriber

EMPLOYER INFORMATION SECTION MUST BE COMPLETED BY EMPLOYER

• Legal Name of Employer.

• Occupation / Title must coincide with those listed on your Application / Insurance Benefit.

EMPLOYEE SECTION

• Must be completed by employee to determine your eligibility.

• Children between age 19-25 must be full-time students at an accredited college or university.

• Give beneficiary's complete name, relationship to you and Full address.

• If beneficiary is a married woman, show given name (Mary J. Jones **Not** Mrs. John Jones).

• If you wish to designate any arrangement other than the primary/contingent designation, please send complete instructions to Group Title, GE Group Life Assurance Company; Special forms will be prepared.

NOTE: Employer may not be designated as a beneficiary.

Full signature (must be in ink) of employee is required and must be dated

Notices Concerning Medical Coverage required by the Health Insurance Portability and Accountability Act of 1996:

Pre-Existing Conditions (not applicable to pregnancy). - The medical plan contains a pre-existing condition limitation that may apply to you and/or your dependents. Any applicable pre-existing condition limitation will be reduced by your prior creditable coverage, if any. You have the right to request a certificate of creditable coverage from your prior health plan and we will assist you in obtaining this certificate, if necessary. For additional information regarding the plan's pre-existing condition limitation, please see your plan administrator. Late entrants to the plan may be subject to an increased pre-existing condition limitation.

Special Enrollment Rights. - If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this medical plan, provided you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the date of the marriage, birth, adoption or placement for adoption.



Enrollment Request

GE Group Life Assurance Company
Attn: Group Eligibility

Add Change Termination Correction

Date: _____ Reason: _____

Employer Information - to be completed by Employer

| | | |
|---|----------------------------------|----------|
| 1. Group Account Number | 2. Other Group Account Number(s) | 3. Class |
| 4. Name of Employer | | |
| 5. Employer's Address (Number, Street, City, State, ZIP Code) | | |

Employee Information - to be completed by Employee

| | | | |
|--|--|--|---|
| 6. Name of Employee (Last, First, M.I.) | | 7. Social Security Number | |
| 8. Employee's Address (Number, Street, City, State, ZIP Code) | | 9. Employee's Home Phone No. | |
| 10. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female | 11. Date of Birth (Mo., Day, Yr.) | 12. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married | 13. My employment is covered under Union Collective Bargaining <input type="checkbox"/> Yes |
| 14. Hours worked weekly for this employer <input type="checkbox"/> Active <input type="checkbox"/> Retired <input type="checkbox"/> COBRA (Excluding Overtime) | 15. Date Employed (Mo., Day, Yr.) <input type="checkbox"/> Full-Time ____/____/____ <input type="checkbox"/> Part-time ____/____/____ <input type="checkbox"/> Rehire ____/____/____ <input type="checkbox"/> Return from Layoff ____/____/____ | | |
| 16. Basic Earnings <input type="checkbox"/> Hourly _____ Hrs/Wk \$ _____ <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Annually | 17. Employee's Occupation (Title) | | |

NOTE: If you refuse Medical or Dental benefits for yourself, you automatically refuse these benefits for any dependents. If you refuse any benefit now, and later request to add that benefit, your coverage may be limited as outlined in the certificate. Some or all of these benefits may be funded by your employer. Administrative Services and forms provided by GE Group Administrators, Inc. does not imply liability for GEGA for claim payment. See your employer for details. THOSE BENEFITS COMPLETELY PAID FOR BY THE EMPLOYER CANNOT BE REFUSED. All benefits may not be available; check with your plan administrator. Indicate your choice by checking the appropriate box.

Group Benefits Requested - to be completed by Employee

| | | |
|---|--|---|
| Life/AD&D <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse | Dependent Life/AD&D <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse | Supplemental Life/AD&D <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse |
| Dental <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse | Medical <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse | Weekly Indemnity <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse |
| Dependent Dental <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse | Dependent Medical <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse | Long Term Disability <input type="checkbox"/> I Elect <input type="checkbox"/> I Refuse |

*If you have refused Medical or Dental, is it because you have other Group Coverage?
Medical Yes No Dental Yes No

**If you have refused Medical or Dental for your dependents, is it because they have other Group Coverage?
Medical Yes No Dental Yes No

Please Complete The Following Question If You Are Electing Medical Coverage

Did you or your dependent have prior medical coverage? Yes If so, Single Family Dependent(s)
 Individual Policy Group Policy HMO Other _____
Name of Carrier _____ Termination date of Coverage ____/____/____
Reason for Termination _____

Please complete this *entire* section if you are selecting Medical and/or Dental Coverage.

| Last Name | First Name | M.I. | Date of Birth | Sex | Social Security Number |
|-----------|------------|------|---------------|-----|------------------------|
| Employee | | | | | / / |
| Spouse | | | | | / / |
| Child | | | | | / / |
| Child | | | | | / / |
| Child | | | | | / / |

Student Verification - Please complete the following if any child listed is a full-time college student.

Name of child: _____ School Name and Address: _____
Course of Study: _____ Semester: _____ Anticipated date of graduation (month/year): _____

Beneficiary Designation - applies ONLY if life insurance is being elected at this time

| | | | |
|----------------------------|-----------------------------|--------------|---------|
| 22. Primary - Last Name | First Name & Middle Initial | Relationship | Address |
| 23. Contingent - Last Name | First Name & Middle Initial | Relationship | Address |

NOTE: You may designate a new beneficiary at any time, subject to the conditions and provisions of the Group Policy.

I request benefits under the group coverage issued by GE Group Life Assurance Company and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply, or as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct and that this request is subject to the representations made on the reverse side of this request which I have read and fully understand. I understand and agree that any incorrect statements material to the risk made by me in this enrollment request may invalidate my benefit(s) and result in claim denials and that all statements made by me shall be deemed representations and not warranties.

I designate the beneficiary(ies) shown above to receive all sums which may become due on account of my death under this group coverage. I understand that proceeds will be payable in equal shares to those primary beneficiaries who survive me but if no primary beneficiary survives such proceeds will instead be payable in equal shares to those contingent beneficiaries who survive me.

To the best of my knowledge I am an employee working the weekly hours shown above at the employer's regular place of business, and I agree any information shown above including the refusal section is correct and my signing below indicates that I understand all information given is subject to verification.

I agree that my Employer acts as my agent in all dealings with the Plan(s), and that all notices given to him are binding upon me. I also agree that my participation in the benefit(s) and the authorization and agreements stipulated herein are subject to any future amendments to the Plan(s).

I certify that I have read the reverse side of this form.

24. Date

25. Signature

Any person who knowingly and with intent to defraud any insurance company or other person either: 1) files an application for insurance or statement of claim containing any materially false information, or 2) conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime. VIOLATIONS ARE SUBJECT TO CRIMINAL PROSECUTION AND MAY ALSO RESULT IN SUBSTANTIAL CIVIL PENALTIES.

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

In Virginia the above statements do not apply.

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

In Louisiana, any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.