



Voluntary Life Enrollment Application

GE Group Life Assurance Company
PO Box 1471
Waterbury CT 06721

Employer	Account Number
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1. Employee Information

Name (Last, First, M.I.)	Social Security Number	Date of Birth
Address (No., Street, City, State, ZIP Code)		

2. Employment Information

Regular Place of Employment (City, State)	Date employed Full-time (Mo., Day, Yr.)	Basic Earnings \$ _____ per _____
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3. Spouse Information

Name of Spouse (Last, First, M.I.)	Social Security Number	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
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4. Beneficiary Designation - (See plan administrator for beneficiary instructions)

Primary Beneficiary (Last Name, First Name & M.I.)/Relationship to Employee	Address
Contingent Beneficiary (Last Name, First Name & M.I.)/Relationship to Employee	Address

5. Coverage Information

Coverage Requested: Employee Only Employee and Children Employee and Spouse Employee and Eligible Dependents

Benefit Requested: Employees may elect an amount, in \$10,000 increments, up to \$300,000 or five times salary, whichever is less.* Spouse may elect amounts in \$5,000 increments up to a maximum of 50% of the employee's coverage amount or \$50,000, whichever is less. Indicate amounts elected below (Check with your employer for the available non-medical issue amount):
If sections 1-6 are incomplete your benefit will be limited to the non-medical issue amount. Please see reverse side if benefits elected are in excess of the non-medical issue amount.

Employee- \$ _____,000.00 (minimum of \$20,000)** Spouse- \$ _____,000.00 (minimum of \$10,000)**

*In Texas, the total amount of Life Insurance (basic life plus voluntary life) cannot exceed the greater of \$250,000 or seven times salary. In Wisconsin, the total amount of Life Insurance (basic life plus voluntary life) cannot exceed \$200,000.

**In Washington, the Employee minimum is \$30,000 and the Spouse minimum is \$15,000.

6. Have you or your dependents used any tobacco products in the past 36 months?

Employee: Yes No Spouse: Yes No

7. Application & Authorization Section

I have read and personally responded to each of the preceding questions and have confirmed that the information is correct as to myself and my dependents.

I request insurance under the group coverage issued to my employer by GE Group Life Assurance Company (GEGGLAC); authorize deductions from my earnings of any required contributions for any insurance for which I am or may later become eligible; and designate the beneficiary(ies) shown to receive all sums which may become due on account of my death under this group coverage. I certify that: (1) I am employed by the employer listed and at present am working at least 30 hours per week for this employer at the regular place of business; (2) the information shown is correct; (3) I understand that any incorrect statements may result in my coverage or my dependents' coverage being terminated, rescinded and/or claims not paid; (4) I have read this form; (5) I authorize GEGGLAC to verify all information.

I authorize the following persons and/or institutions that have any records or knowledge of me, my employment, and my health or my dependents or their health to give any such information to GEGGLAC, its reinsurers, and its legal representatives: Any physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, or any similar organization, institution or person, any employer, group policyholder or certificate holder. I understand that the information released to GEGGLAC will be used to determine eligibility for the insurance requested. GEGGLAC may redisclose such information for that purpose to the employer or union connected with the group insurance coverage involved herein, the group policyholder or certificate holder, or their representatives, to any reinsurer, and to any person or entity performing a business or legal function for the benefit of GEGGLAC. The information may also be redisclosed as otherwise specifically permitted or required by law.

This authorization extends to and includes HIV-related information, AIDS or AIDS-related disorders or information relating to alcohol or drug abuse or mental health care to the extent permitted by law. This authorization or photo copies of it will be valid for two and one-half years following the date signed, unless otherwise required by law. I understand that I am entitled to a photocopy of this authorization upon request.

Signature of Employee

Date



General Application Instructions

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- Complete questions 1 through 6.
- If selecting an amount in excess of the benefit available without underwriting, you will also need to complete the enclosed health statement.
- Sign and date authorization. If not signed, the form will be returned for your signature.

Confidentiality of Medical Information

NOTE: In this section, all references to "you" apply to both employee and dependents.

Information given in your group enrollment card and health statement may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted. Information regarding your insurability will be treated as confidential. GE Group Life Assurance Company, or its reinsurers, may however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members.

If you apply to another Bureau member company for life or health insurance, or submit a claim for benefits to such a company, the Bureau upon request will supply such company with the information it may have. GE Group Life Assurance Company or its reinsurers may also release information in your file. (Non-medical information will be disclosed to you and medical information will be disclosed to you and your attending physician.)

If you question the accuracy of the information, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The Bureau's information office is at P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone 617-426-3660

Access to Personal Information

Personal information may be collected from persons other than the individual or individuals proposed for coverage. Such information as well as other personal or privileged information subsequently collected by the insured institution or agent may in certain circumstances be disclosed to third parties without authorization. You have the right to see your personal records and correct personal information collected. You will be furnished with our detailed Description of Information Practices form (ESG GL 1607) upon request from either the firm administrator and/or the Home Office.

Instructions on Naming Beneficiary

1. Give complete name of beneficiary and relationship to you. (Indicate present address.)
2. If beneficiary is a married woman, show given name. (Mary J. Doe, not Mrs. John M. Doe.)
3. Unless otherwise designated, proceeds will be payable in equal shares to those primary beneficiaries who survive you, but if no primary beneficiary survives you, such proceeds will instead be payable in equal shares to those contingent beneficiaries who survive you.
4. If you wish to designate any arrangement other than the Primary-Contingent designation, please send complete instructions to Group Title Department, GEGLAC, 100 Bright Meadow Boulevard, P.O. Box 1955, Enfield, CT 06083-1955, and special forms will be prepared.

NOTE: This is a revocable beneficiary designation meaning that a new beneficiary may be designated from time to time subject to the conditions and provisions of the Group Policy.

Fraudulent Insurance Act - State law, in some states, requires the following statement:

A person commits a fraudulent insurance act, which is a crime, if he or she knowingly and with intent to defraud any insurance company or other person, either:

1. Files an application for accident and health insurance or statement of claim containing any materially false information; or
2. Conceals for the purpose of misleading, information about any fact that is material to a claim.

VIOLATIONS ARE SUBJECT TO CRIMINAL PROSECUTION AND MAY ALSO RESULT IN SUBSTANTIAL CIVIL PENALTIES.