Globe Life Benefits

Globe Life And Accident Insurance Company
3700 S Stonebridge Dr
McKinney, TX 75070
www.globelifebenefits.com

Please return this completed form to: inshore@pathianadministrators.com for processing.

Group Limited Indemnity Policy

ENROLLMENT FORM

PARTICIPATING EMPLOYER INFORMATION

Group Name	Group Number

EMPLOYEE INFORMATION

Last Name	**First** Name	M.I.	Social Security #	Date of Birth

Street Address	Apt. No.	City	State	Zip

Home Phone:	Work Phone:	Gender	Marital Status
		☐ M ☐ F ☐ X	☐ Single ☐ Married ☐ Partnered

Job Title	Division	Date of Employment

Enrollment Type

☐ New Enrollment

☐ Change: (☐ Address ☐ Family status ☐ Name ☐ Other: ________________________) Date of Change: _____________

Eligibility:

Are you currently Actively at Work and able to perform the duties of your occupation? ☐ Yes ☐ No

If No, are you an early retiree? ☐ Yes ☐No; If Yes, please provide your date of retirement: ___________

If Yes, how **How** many hours are you regularly working per week with your current employer? ___________ Hours per week

Elections:

☐ Employee Only ☐ Employee & Spouse/Domestic Partner ☐ Employee & Child(ren) ☐ Employee & Family

☐ Employee Only ☐ Employee & 1 Dependent ☐ Employee & 2 or more Dependents

☐ Plan 1 ☐ Plan 2 ☐ Plan 3

DEPENDENT INFORMATION (Complete only for Dependents to be covered under this plan)

Last Name	**First** Name	M.I.	Relationship	Date of Birth	Gender
					☐ M ☐ F ☐ X
					☐ M ☐ F ☐ X
					☐ M ☐ F ☐ X
					☐ M ☐ F ☐ X
					☐ M ☐ F ☐ X
					☐ M ☐ F ☐ X

BENEFICIARY DESIGNATION (For Term Life and Accidental Death & Dismemberment Benefits)

Designation is only valid if signed, dated and delivered to the Participating Employer during your lifetime. Payment will be made in equal shares unless otherwise indicated. **Total of all shares must equal 100%.**

Primary Beneficiary – Full Name	Relationship to You	Phone Number	SSN or DOB	% of Benefit
Contingent Beneficiary – Full Name	Relationship to You	Phone Number	SSN or DOB	% of Benefit

☐ Check here if you need space for more beneficiaries. Attach a separate page with all required information; sign and date the page.

SIGNATURE (This form must be signed and dated to be valid.)

AUTHORIZATION AND ACKNOWLEDGMENT

I hereby declare that all the statements made above and on the reverse side are, to the best of my knowledge and belief, true and complete and that I understand they are the basis on which insurance requested by me may be issued.

All statements made by me are representations and not warranties. No statement made by me will be used to contest the insurance provided by the Policy, unless:

1. it is contained in a written statement signed by me; and
2. a copy of the statement is furnished to me.

I agree that a digital copy or photocopy of this form shall be as valid as the original, and that it shall be valid for 24 months from the date signed. I also understand that I, or the person authorized to act on my behalf, is entitled to receive a copy of this authorization form.

I designate the person(s) named on this form as beneficiary(ies) for any Benefit Amounts payable upon my death for the Term Life and Accidental Death & Dismemberment insurance coverage applied for in this Enrollment Form. With such designation, any previous designation of a beneficiary for such coverage is hereby revoked. I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage I have selected. I further understand that a treatment, which results from a Pre-Existing Condition, will not be covered if the treatment begins within 3, 6, 9, 12 months after the effective date of insurance coverage.

THE POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL TO HEALTH INSURANCE AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THE POLICY DOES NOT SATISFY THE MINIMUM ESSENTIAL COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT.

AUTHORIZATION AND ACKNOWLEDGMENT - I certify that the above information is true and correct to the best of my knowledge and belief.

Please continue to read below for special notices required by state law.

X ____ ______________________

Signature of Proposed Insured Date Signed

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of committing a fraudulent insurance act, which is a crime.

Alabama: 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 restitution, fines or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Arkansas, Louisiana, Massachusetts, Rhode Island, and West Virginia. 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.

California: For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime

and may be subject to fines and confinement in state prison.

Colorado. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Delaware. Any person who knowingly and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kansas: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any act material thereto may be guilty of fraud as determined by a court of law, and may be subject to criminal and civil penalties.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638.20.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: 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 CIVIL FINES AND CRIMINAL PENALTIES.

Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Oklahoma: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Oregon: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines or denial of insurance benefits.

Vermont: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.