

**TEACHERS PROTECTIVE MUTUAL
SMALL EMPLOYER TRUST
EMPLOYEE APPLICATION FORM**

Employer Name _____
Group Number _____

Purpose of this Application	<input type="checkbox"/> Initial Enrollment
	<input type="checkbox"/> Special Enrollment
	<input type="checkbox"/> Increase Benefits
	<input type="checkbox"/> Late Entrant

EMPLOYEE NAME _____
Resident Address _____
Street _____
City _____ State _____ Zip _____
Resident Phone () _____

Social Security Number _____
Empl. Class _____ # Hrs. Worked Wkly _____
Job Title/Duties _____
Date Hired Full-Time _____

Marital Status Single Married Divorced Legal Separation Income \$ _____ Hourly Weekly Monthly

Coverage Requested

- All group coverage provided through Employer with Teachers Protective Mutual
- All group coverage provided through Employer with Teachers Protective Mutual excluding*:
 - Dental/Hearing/Vision
 - Disability
 - Medical
 - Dependent Coverage

* I acknowledge that I have been given an opportunity to participate in the excluded coverage(s) offered through my employer with Teachers Protective Mutual and have declined to participate. I understand that if I desire to obtain the excluded coverage(s) at some later date, evidence of insurability satisfactory to Teachers Protective Mutual may be required. See the Special Notice Regarding Declined Participation on the back of this application. **If Medical or Dependent Coverage is declined due to other coverage, check this box:**

Life Insurance Beneficiary _____ Relationship _____

PERSONS TO BE COVERED:

Full Name	Relationship	Sex	Birth Date	Age	Height	Weight	Occupation
	Self						
	Spouse						
	Child						
	Child						
	Child						

HAVE YOU OR ANY LISTED DEPENDENT:

- | | | |
|--|--------------------------|--------------------------|
| | YES* | NO |
| a. Been medically advised of or treated for high blood pressure, chest pain, heart trouble, stroke or other circulatory problem? ... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Been medically advised of or treated for cancer, tumor, diabetes, kidney or bladder disease, organic brain disease, disorder of reproductive organs, arthritis, back trouble, lung or respiratory disease, AIDS or other immune disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Been medically advised of or treated for nervous or mental disorder, drug addiction or substance abuse, or alcoholism? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Been medically advised within the past 12 months to have any diagnostic testing, treatment or surgery? | <input type="checkbox"/> | <input type="checkbox"/> |

Are you or any listed dependent currently pregnant, disabled, physically or mentally impaired, or under doctor's care other than listed above?.....

* For any "Yes" answer, circle appropriate item above and list details including name of person, date(s), nature of any treatment, and full name and address of physician, hospital, etc. _____

I am requesting coverage under the group policy issued by Teachers Protective Mutual Life Insurance Company, and also authorize my employer to deduct any required contribution for insurance from my earnings.

I represent that I am actively and regularly working at least 25 hours a week for the employer named on this application, and that the statements contained in this application are true and complete to the best of my knowledge and belief. I understand that the insurance is not now in effect, but will become effective as outlined in the Certificate and Master Policy. Should I be absent from work on that date by reason of accident or sickness, I understand that the insurance will not become effective until I return to work. The benefits, limits, and other coverage provisions shall be as outlined in the Master Policy.

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company or other organization, institution or person that has any records or knowledge of me or my health, or that of my family, to give to Teachers Protective Mutual Life Insurance Company, or its reinsurers, any such information. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for 2 years from the date below.

Employee's Signature

Date

Printed Name of Agent

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.

NEW ENTRANT NOTICE

If you or any dependents have a condition (whether physical or mental) for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period ending on the Enrollment Date, you, he or she may not be covered for such condition until you, he or she has been enrolled for 1 year (18 months for Late Entrant) under this contract. The exclusion period is reduced by any Creditable Coverage you, he or she has as of the Enrollment Date.

SPECIAL NOTICE REGARDING DECLINED PARTICIPATION

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 plan, provided that 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 marriage, birth, adoption, or placement for adoption.

Remarks or Special Requests:

Teachers Protective Mutual Life Insurance Company
Lancaster, Pennsylvania