

ENROLLMENT FORM FOR PERSONAL ACCIDENT INSURANCE

Underwritten by: AIG Life Insurance Company

Complete the following to enroll:

Company Name: _____ **Master Policy #:** _____

Employee's Full Name: _____ Social Security Number: ____ - ____ - ____

Address: _____ City: _____ State: _____ Zip Code: _____

Your Date of Birth: __/__/__ Date Employed: __/__/__ Occupation: _____

Effective Date - For Official Use Only

Select Coverage Option: **Employee Only** **Employee and Family** **Principal Sum:** \$ _____

If you select coverage for your family, benefits for family members will be a percentage of yours.

Employee Beneficiary's Full Name: _____ Relationship: _____ Social Security Number: ____ - ____ - ____

Complete only if you have chosen the Employee and Family Plan - *If you insure your spouse, you are his/her beneficiary unless you specify otherwise below.*

Spouse's Name: _____ Your Spouse's Date of Birth: __/__/__ Social Security Number: ____ - ____ - ____

Spouse's and/or Dependent's Beneficiary if other than Employee: _____ Social Security Number: ____ - ____ - ____

Relationship: _____

Your Effective Date: Your coverage will begin on the later of: 1) the Policy Effective date; 2) the date this Enrollment Form is received by [Policyholder].

I acknowledge that I have read, understand, and agree to the term and conditions of this coverage as detailed in the brochure and I authorize the premium deduction from my pay for the insurance applied for as shown above. I understand that if I purchase more than I am allowed, any excess premiums will be refunded.

I have been given the opportunity for this insurance but I do not desire to participate.

Employee's Signature _____ Date _____

Return first copy to your employer. Retain second copy for your records.