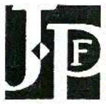

JEFFERSON PILOT FINANCIAL

Jefferson Pilot Financial Insurance Company
P.O. Box 2616, Omaha NE 68103-2616
(800) 423-2765 fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

	Group ID:	Group Policy #:	Billing Division or Location: Manatts Inc

Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name **Manatts Inc.**	County Poweshiek	Employer ZIP 52211	State Iowa
Employee First Name / Middle Initial / Last Name	Social Security Number		Date of Birth
Street Address / City / State / Zip			
Gender:	Marital Status:	Home Phone ( )	Work Phone ( )

Employee Work Information (Complete for ALL Enrollments)

			Full-Time Hire Date:	Rehire Date:

Product Selection (Complete for ALL Enrollments)

Voluntary Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Clas	Effective Date	Type of Coverage	Amount of Coverage	Monthly Premium
	1/1/2010	Voluntary Dental ☒Yes	☐Employee Only	$21.82
			☐Employee/Spouse	$43.80
			☐Employee/Children	$49.36
			☐Employee/Spouse/Children	$74.36

Dependent and Other Insurance Information (Complete only for Dental Coverage)

	Last Name	First Name	Middle Initial	Gender	Date of Birth
Spouse:					
Children:					

Are you or any of your eligible dependents covered by any other dental plan? ☐**YES (If YES, please list)** ☐**NO**

Name of Insured	Insurance Company Name, Phone & Policy Number	Employer

NOTE: A PERSON COMMITS INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Home Office of Jefferson Pilot Financial Insurance Company, and the initial premium is paid to Jefferson Pilot Financial Insurance Company. A delayed effective date will apply if the employee is not actively at work, or a dependent is in a period of limited activity on the date insurance would otherwise take effect

Employee Full Name: ______________________________

Employee Signature: ______________________________ Date: ____________