# PRINTER'S DISABILITY TRUST ENROLLMENT CARD

Check Requested Coverage:

☐ STD ☐ LTD ☐ Managed ☐ Managed 2/50 ☐ Managed 5/50 NEW ☐
☐ 2/50 ☐ 5/50 ☐ LIFE ☐ AD&D REHIRE ☐
NAME CHNG ☐

SS# _____. Date of Birth _____

Name _____ _____ _____
(First) (MI) (Last)

Home Address _____ Phone _____

City _____. ST _____. Zip _____

Sex M ☐ F ☐ Date of Employment _____. Annual Salary _____

Employer _____ Occupation _____

Check one:

☐ Premium contribution for our employees is 100% employer paid.
☐ Premium contribution for our employees is 100% employee paid.
Employee contributions are pre-tax. Yes ☐ No ☐
☐ Premium contribution is shared by the employer & employees*
The breakdown is _____% employer paid and _____% employee paid

Date: _____ Signature _____

Eff. Date _____ Cov. Type _____ Case # _____

**Complete Application Coverage Section(s):**

GROUP LIFE

Please enter the amount of Life Protection you are purchasing.

Person(s) Group Term Amount (in $10,000 increments)

Yourself $ _____ Include AD&D Rider ☐ Yes ☐ No

Your Spouse $ _____. AD&D Rider Not Available

Your Child(ren) ☐ Yes ☐ No. AD&D Rider Not Available

Child(ren)'s Name(s) _____

1. Beneficiary _____ Relationship _____ Percentage _____%
2. Beneficiary _____ Relationship _____ Percentage _____%
3. Beneficiary _____ Relationship _____ Percentage _____%
4. Beneficiary _____ Relationship _____ Percentage _____%