NORTH AMERICAN BENEFITS COMPANY

CERT. NO. | POLICY NUMBER

MUST BE ANSWERED FOR ALL PLANS.

MY LAST NAME | FIRST | INITIAL | SEX ☐ M ☐ F | DATE OF BIRTH MO. DAY YEAR

MY OCCUPATION | NAME OF MY EMPLOYER

AMOUNT OF EARNINGS $ _____ ☐ Hr. ☐ Wk. ☐ Mo. ☐ Yr. | FULL-TIME EMPLOYMENT DATE MO. DAY YEAR | SOCIAL SECURITY NO.

FILL IN WHEN GROUP POLICY PROVIDES DEPENDENT BENEFIT

Do you have eligible Dependents? ☐ Yes ☐ No

Check dependents you wish to insure

☐ Spouse ☐ Children ☐ None

Spouse's Signature _____

Dependent Age 18 Or Older Signature _____

SPOUSE'S DATE OF BIRTH MO. DAY YEAR

IF PLAN REQUIRES PAYROLL DEDUCTIONS COMPLETE THIS PORTION

CONTRIBUTORY LIFE ☐ Yes ☐ No | INSURANCE AMOUNT $_____

WEEKLY INDEMNITY ☐ Yes ☐ No | LONG TERM DISABILITY ☐ Yes ☐ No

IF PLAN PROVIDES LIFE, OR ACCIDENTAL DEATH INSURANCE, COMPLETE THIS PORTION

BENEFICIARY'S LAST NAME | FIRST | INITIAL | AGE | RELATIONSHIP TO EMPLOYEE

Primary _____

Contingent _____

Your benefits will be paid first to the Primary beneficiary(ies). If that person(s) is deceased, benefits will be paid to the Contingent beneficiary(ies). (Legal appointment of guardian is required if minor is named as beneficiary.)

PLEASE READ, DATE AND SIGN THIS PORTION

I am an active, full-time employee. The complete terms of the group insurance coverage will be set forth in the group insurance policy(ies). If my employer requires contributions for the insurance I have selected, I authorize my employer to deduct such contributions from my wages.

_____ Date Signed

_____ Signature of Employee

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WHITE – NABCO YELLOW – Group Policyholder GREEN – Employee's Copy