



MEDICO®

LIFE AND HEALTH INSURANCE COMPANY

P.O. Box 10386

Des Moines, IA 50306-0386

Toll Free 1-800-228-6080

Medico Life and Health Insurance Company

GROUP INSURANCE ENROLLMENT CARD

STATE	GROUP NUMBER	SOCIAL SECURITY NUMBER	

NAME - LAST		FIRST	MIDDLE	DATE OF BIRTH			ANNUAL SALARY		
				MM	DD	YY			
ADDRESS		CITY	STATE	ZIP	LIFE	DEP LIFE	STD	LTD	SUPPLEMENTAL LIFE AMOUNT
					YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/>	YES <input type="checkbox"/> _____
EFFECTIVE DATE		CLASS	FULL-TIME EMPLOYMENT DATE	MARITAL STATUS	SEX	NO* <input type="checkbox"/>	NO* <input type="checkbox"/>	NO* <input type="checkbox"/>	NO* <input type="checkbox"/>
MM	DD	YY	MM	DD	YY	<input type="checkbox"/> SINGLE	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE	
						<input type="checkbox"/> MARRIED			
EMPLOYER'S NAME							OCCUPATION		

PRIMARY BENEFICIARY'S NAME: _____ RELATIONSHIP: _____
 (EXAMPLE: "HELEN LOUISE JONES" - NOT "MRS. H.L. JONES")

CONTINGENT BENEFICIARY'S NAME: _____ RELATIONSHIP: _____

I REQUEST THE GROUP INSURANCE TO WHICH I AM ENTITLED OR TO WHICH I MAY BECOME ENTITLED UNDER THE PROVISIONS OF THE GROUP POLICY OR POLICIES ISSUED BY THE INS. CO. AND I AUTHORIZE THE PROPER DEDUCTIONS, IF ANY, FROM MY EARNINGS AS MY CONTRIBUTIONS TOWARDS THE COST OF THIS INSURANCE.

* THE GROUP BENEFIT PLAN PROVIDED BY MY EMPLOYER HAS BEEN EXPLAINED TO ME THOROUGHLY, AND I UNDERSTAND IT FULLY. I ELECT NOT TO PARTICIPATE AND UNDERSTAND THAT I WILL NOT BE ENTITLED TO ANY BENEFITS PROVIDED BY THE PLAN. I MAKE THIS ELECTION VOLUNTARILY AND UNDER NO COMPULSION OR DURESS.

X

YOUR SIGNATURE _____

DATE _____