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

STATE	GROUP NUMBER	SOCIAL SECURITY NUMBER

GROUP INSURANCE ENROLLMENT CARD

NAME – LAST	FIRST	MIDDLE	DATE OF BIRTH (M M / DD / Y Y)	ANNUAL SALARY

ADDRESS	CITY	STATE	ZIP

EFFECTIVE DATE (M M / D D / Y Y)	CLASS	FULL-TIME EMPLOYMENT DATE (M M / D D / Y Y)	MARITAL STATUS	SEX
			☐ SINGLE ☐ MARRIED	☐ MALE ☐ FEMALE

LIFE	DEP LIFE	STD	LTD	SUPPLEMENTAL LIFE AMOUNT
YES ☐	YES ☐	YES ☐	YES ☐	YES ☐ _____
NO* ☐	NO* ☐	NO* ☐	NO* ☐	NO* ☐

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

38 112 0984 0615 US