

Globe Life And Accident Insurance Company
Administrative Office: Globe Life Center, Oklahoma City, Oklahoma 73184
Group Enrollment Form for Accidental Death Policy

Benefit Amount

\$3,000

(\$3,000 spouse, \$1,000 each child)

☐ **Annual Mode of Premium**

Payment Type

☐ Send Premium Notice

☐ Automatic Payment Plan

Day of the Month to Draft Bank (01-28) _____

1. Proposed Insured/Applicant: _____ First Middle Last			
2. Mailing Address: _____ Street City State Zip			
3. Age Last Birthday _____	4. Date of Birth: ____/____/____	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
6. Home Telephone _____ Area Code Number		Work Telephone _____ Area Code Number	
7. Social Security Number _____		8. Email Address _____	
9. Beneficiary		Relationship	
10. Proposed Insured's Spouse		Social Security Number	Date of Birth
First	Middle	Last	____/____/____
11. Child's Name		Social Security Number	Date of Birth
First	Middle	Last	____/____/____
A.			____/____/____
B.			____/____/____
C.			____/____/____
D.			____/____/____
E.			____/____/____
F.			____/____/____

Is the insurance applied for intended to replace or change any coverage now in force with this or any other company? If "Yes," comply with the application Replacement Regulation or Rule. ☐ Yes ☐ No

DECLARATION AND AUTHORIZATION

I hereby declare that the statements recorded above are true and complete to the best of my knowledge and belief with respect to any proposed insured. I agree that: (1) no policy will be binding upon the Company unless upon its date of issue and delivery each proposed insured is alive; (2) no agent has authority to accept risks or make or change contracts or waive the Company's rights or requirements. I understand and agree that the Company reserves the right during the first year the policy is in force, to restrict beneficiaries to designations acceptable to the Company. Except with respect to a minor child of mine, this application is made with the knowledge and consent of the proposed insured.

Date

Application State

Agents' Signature

Agents' Writing Number

Signature of Proposed Insured/Applicant