



**Employee Application to Associated Mutual Insurance**

3809 Lake Eastbrook Blvd SE, Grand Rapids, MI 49546

options@associatedmutual.org

**SUBSCRIBER INFORMATION**

Name of Employee (Last)	(First)	(Middle)	Social Security Number
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Address of Employee (Street)	(City)	(State)	(Zip Code)
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Name of Employer	Job Title	Job Class	No of Hours Worked in Normal Week
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Date of Birth	Date Employed	Gender <input type="checkbox"/> Female <input type="checkbox"/> Male	Basic Salary From Employer \$	<input type="checkbox"/> semi-monthly <input type="checkbox"/> hourly <input type="checkbox"/> monthly <input type="checkbox"/> weekly <input type="checkbox"/> annual
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DEPENDENT'S LAST NAME	FIRST NAME	MI	RELATIONSHIP	DATE OF BIRTH
1.				
2.				
3.				
4.				
5.				
6.				

BENEFICIARY'S LAST NAME	FIRST NAME	MI	RELATIONSHIP	AGE
1.				
2.				

Living Trust       My Estate

If more than one beneficiary is designated, distribution will be equal unless otherwise indicated.

**OPTIONAL COVERAGE ENROLLED FOR IF AVAILABLE THROUGH YOUR GROUP PLAN**

Dependent Life <input type="checkbox"/> Yes <input type="checkbox"/> No	Short Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Long Term Disability <input type="checkbox"/> Yes <input type="checkbox"/> No	Vision <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Care Benefit <input type="checkbox"/> Yes <input type="checkbox"/> No
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Amount of Life Coverage: \$ \_\_\_\_\_ \*Evidence of Insurability may be required.

*I hereby apply for group insurance as indicated above and authorize my employer to make the necessary deductions from my earnings to apply toward the premiums, if required. I understand that all insurance coverages will become effective according to the terms of the contract.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Dated