Assurity®
Assurity® Life Insurance Company
Post Office Box 82533, Lincoln, NE 68501-2533
402-476-6500 | 800-276-7619 | FAX 877-864-6630

GROUP PARTICIPANT ENROLLMENT FORM

PLEASE PRINT WITH BLACK INK

☐ **New Enrollee**
☐ **Coverage Change**

Group Name Hand in Hand Location _____ Requested Issue Date (MM/DD/YYYY) 1 / 1 / 2026

A. Participant Information

Applicant's Legal Name (First, Middle, Last)			Date of Birth (MM/DD/YYYY) / /
Applicant's Mailing Address (Street Address)	(City)	(State)	(ZIP+4)
Applicant's Email Address			Personal Phone Number ( )
☐ Male ☐ Female	Social Security No.	Birth State/Country	
Date of Employment (MM/DD/YYYY) / /	Hours per week	Annual Salary $	If enrolling in Disability

Are you employed at least 20 hours per week, working your normally scheduled hours and able to perform the regular duties of your job? ☐ Yes ☐ No
If NO, please explain.

During the past **12 months**, has any Proposed Insured used any form of tobacco or nicotine-based products or substitutes such as patches or gum?
Applicant ..... ☐ Yes ■ No
Spouse ..... ☐ Yes ■ No

SPOUSE INFORMATION:

Spouse's Legal Name (First, Middle, Last)			Date of Birth (MM/DD/YYYY) / /
☐ Male ☐ Female	Social Security No.	Birth State/Country	

CHILD INFORMATION: If additional space is needed, please attach a separate sheet of paper.

Child's Legal Name (First, Middle, Last)	Relationship to Applicant	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY) / /
Child's Legal Name (First, Middle, Last)	Relationship to Applicant	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY) / /
Child's Legal Name (First, Middle, Last)	Relationship to Applicant	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY) / /
Child's Legal Name (First, Middle, Last)	Relationship to Applicant	☐ Male ☐ Female	Date of Birth (MM/DD/YYYY) / /

B. Voluntary Benefit Election — Completion of a Statement of Health and/or Statement of Insurability form may be required for coverage to be approved.

Note: Coverage is for new elections only. Existing coverage will remain in force unless cancelled by You.
Coverage not elected will be considered refused even if not specifically declined.

Accident Expense	☐ Yes ☐ No	☐ Plan 1 ☐ Plan 2	☐ Applicant Only ☐ Applicant/Spouse ☐ Applicant/Child ☐ Family	
Hospital Indemnity	☐ Yes ☐ No	☐ Applicant Only ☐ Applicant/Child ☐ Applicant/Spouse ☐ Family		
Disability Income	☐ Yes ☐ No	Weekly Benefit Amount: $	Benefit Period: ☐ 13-week ☐ 26-week Elimination Period: 7/7 days 7/7 days	
Term Life	☐ Yes ☐ No	☐ 10-Year ☐ To Age 70		
	Applicant Benefit: $	Spouse Term Rider ☐ Yes ☐ No	Children's Term Rider ☐ Yes ☐ No	

Applicant's Name _____

C. Beneficiaries — Unless shown differently below, survivors share equally. If additional space is needed, attach a separate sheet of paper.

Applicant Beneficiaries

Legal Name *(First, Middle, Last)*	Relationship	P=Primary C=Contingent	Date of Birth	Social Security No.	Share %
			/ /		
			/ /		

D. Certification and Authorization

I certify that the statements and answers provided in this enrollment form were made by me, are complete and true, and have been correctly and fully recorded. I agree that this enrollment form constitutes my application and shall form a part of the certificate if attached thereto. My statements and answers are offered as an inducement to grant insurance, and I understand that Assurity may use misstatements or misrepresentations in the application to contest the validity of any coverage provided. I understand that any premiums deducted before the issue date of the certificate are pre-paid premiums and will be applied to coverage beginning on the issue date. If the certificate is not issued, Assurity will refund any premium deductions it receives. I further authorize my employer to deduct from my salary or wages the necessary premium for the coverage(s) requested *(including dependents' coverage)*.

For Health Products Only: I further understand that the insurance applied for shall be in force as of the certificate issue date shown on the certificate schedule and not the date the application is signed.

For Life Products Only: Coverage issued on this enrollment form for any person starts on the date of this enrollment, ONLY IF that person is insurable on that date, at Assurity's standard rates according to its underwriting practices, for the amount of life insurance and any additional benefits applied for.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a substantial civil penalty where and to the extent allowed by state law.

Signature of Primary Proposed Insured _____ on / /