Personnel Application Sheet

Date: ____ / ____ / _____

Facility ______________________

State App Signed: ______________

PAY CYCLE	☐ Weekly	☐ Bi-Weekly	☐ Monthly
	☐ Semi-Monthly	☐ 10 Month Employee	☐ Annually

EMPLOYEE ID # (6-8 digits)	POSTAL EASE/HR LINK/EMPLOYEE EXPRESS# (4 digits):
PASSWORD	Locked in Premium Amount

Gender	FIRST NAME	MI	LAST NAME	SOCIAL SECURITY NUMBER
☐ Male ☐ Female				_____ - _____ - _____

MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

DATE OF BIRTH (mm/dd/yyyy)	AGE	STATE OF BIRTH	DRIVER'S LICENSE #	STATE	EXP DATE
____ / ____ / _____					

MAILING ADDRESS	APT	CITY	STATE	ZIP CODE

TELEPHONE: (HOME)	(MOBILE)	(WORK)

BEST TIME TO CONTACT: ☐ Morning ☐ Afternoon ☐ Evening	EMAIL ADDRESS:

☐ SMOKER ***☐ NON-SMOKER*** *Have you **EVER** used Tobacco?* *☐ YES* *☐ NO* ***When*** *?* ___ / ___ / ____

EMPLOYMENT

EMPLOYER NAME		☐ TEMPORARY EMPLOYEE ☐ PERMANENT EMPLOYEE ☐ ANNIVERSARY DATE: _____ / _____ / _____	
START DATE (mm/dd/yyyy) _____ / _____ / _____	ANNUAL INCOME	OCCUPATION	☐ FULL TIME ☐ PART TIME ☐ SEASONAL

HEALTH

HEIGHT _______ WEIGHT _______	DATE OF LAST VISIT _____ / _____ / _____	REASON ☐ CHECK UP ☐ OTHER _______________
PHYSICIAN NAME	PHONE NUMBER	ADDRESS

Asthma	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Other	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Anxiety/Depression	☐ Yes	☐ No	_______________		

Medication ______________________ Dosage ____________ Frequency ______________

Medication ______________________ Dosage ____________ Frequency ______________

BENEFICIARY

Name ____________________	Relationship ____________	DOB ____ / ____ / _____	☐ (P) ☐ (C)
Name ____________________	Relationship ____________	DOB ____ / ____ / _____	☐ (P) ☐ (C)
Name ____________________	Relationship ____________	DOB ____ / ____ / _____	☐ (P) ☐ (C)
Name ____________________	Relationship ____________	DOB ____ / ____ / _____	☐ (P) ☐ (C)

PROPOSED INSURED (***CHILD TERM RIDERS - 17 YRS & YOUNGER***)

☐ (M) ☐ (F) **NAME** ____________________	**DATE OF BIRTH** ___ / ___ / _____	**AGE** _____	**HEIGHT** _____	WEIGHT _____
☐ (M) ☐ (F) **NAME** ____________________	**DATE OF BIRTH** ___ / ___ / _____	**AGE** _____	**HEIGHT** _____	WEIGHT _____
☐ (M) ☐ (F) **NAME** ____________________	**DATE OF BIRTH** ___ / ___ / _____	**AGE** _____	**HEIGHT** _____	WEIGHT _____
☐ (M) ☐ (F) **NAME** ____________________	**DATE OF BIRTH** ___ / ___ / _____	**AGE** _____	**HEIGHT** _____	WEIGHT _____

PROPOSED INSURED (***SPOUSE AND THOSE 18 YRS & OVER***)

☐ (M) ☐ (F) **NAME** ____________________	**DATE OF BIRTH** ___ / ___ / _____	**EMPLOYED** ☐ (Y) ☐ (N)	**SMOKER** ☐ (Y) ☐ (N)
☐ (M) ☐ (F) **NAME** ____________________	**DATE OF BIRTH** ___ / ___ / _____	**EMPLOYED** ☐ (Y) ☐ (N)	**SMOKER** ☐ (Y) ☐ (N)

For Representative(s) Use Only:

Written By: ____________________

Set Up By: ____________________

Face Amount: $ __________

☐ Term ☐ UL ☐ WL

☐ HOSP ☐ DI ☐ ACC ☐ CAN

Premium: $ ____________ BIWEEKLY

Riders: ☐ ADB ☐ WOP ☐ CTR ☐ GOP