3000 INSURANCE GROUP

Group Accidental Death & Dismemberment Insurance

Enrollment Form

Group Master Policyholder: **Trustee of Oklahoma Professionals Insurance Trust**

Group Master Policy Number: **1246**

Enrolling Group: ☐**Oklahoma Bar Association** ☐**Oklahoma Society of CPAs** ☐ **Oklahoma Dental Association**

☐ **Association of Nurse Practitioners** ☐ **Oklahoma Association of Realtors** ☐ **Oklahoma Association of Optometric Physicians**

☐**Member of the Enrolling Group** **Date of Membership:**_____

☐**Employee of a Member** **Date of Hire:**_____

If an Employee: Name and Address of Member/Firm: _____

_____

Member/Employee's Full Name:_____ **Date of Birth:**_____ ☐M ☐F

Mailing Address:_____ **Social Security Number:**_____

City:_____ **State:**_____ **Zip Code:**_____ **Phone Number:**_____

Email Address:_____

You must be a member or an employee of a member of an Enrolling Group to enroll for coverage. The member or employee must be insured to cover dependents.
Please make your enrollment election below, enter the Principal Sum and, if you are requesting coverage for your dependents, provide their full name and date birth. If you need more space, list additional children on a separate sheet of paper and send it to us with your enrollment form.

Plan: ☐Member or Employee Only ☐Family Plan ☐Check here if You are currently insured and requesting a Plan change

Principal Sum: $_____ (Enter an amount from $100,000 to $500,000 in increments of $25,000)

Your Beneficiary *: _____ **Relationship:** _____

** Under the Family Plan, You are the beneficiary of Your Spouse and Children.*

List all eligible dependents:

	Full Name	**Date of Birth**
☐ Spouse	_____	_____
☐ Children	_____	_____
	_____	_____
	_____	_____

I understand and agree that coverage will not take effect until the first day of the month after my enrollment form and first premium for the required amount are received by Unimerica Insurance Company.
WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the pro- ceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Member/Employee's Signature_____**Date**_____

Please send your fully completed form to: 3000 NW 149th Street | Oklahoma City, OK 73134

Underwritten on Policy Form ADD-6001 A (UIC) NMOD OK by: Unimerica Insurance Company, Milwaukee, Wisconsin 53226 Association Administrative Address: P.O. Box 17828, Portland, Maine 04112-8828

Form ADD-6001 E
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