OVERBROOK FRIEDLANDER PROGRAMS

Employee Information *(This is not an application. Information is to be used for application preparation and policy administration only)*

Name _____ Birth Date _____ / _____ / _____ SSN _____ - _____ - _____ Gender □ M □ F State of Birth _____
Street _____ Apt # / Bldg # / Floor _____ City _____ State _____ Zip _____
Phone: (_____) _____ - _____ (□ Home □ Work □ Cell) Best Time to Call _____ Employer _____
Hire Date _____ / _____ / _____ Job Title _____ Job Duties _____ Annual Salary $_____
Height _____ ft. _____ in. Weight _____ Drivers License # _____ State of Issue _____
Email _____ Email Policies □ Yes □ No

Beneficiary Information *(Beneficiary will be ESTATE unless you specify individual(s).)*

Benefits will not be paid to a minor child until a guardian for the financial estate of the child has been appointed by the court or otherwise set forth by the policy owner or by law.

Primary
Name _____ Birth Date _____ / _____ / _____ Gender □ M □ F
Street Address _____
City _____ State _____ Zip _____ Phone (_____) _____ - _____
Relationship to Employee _____ % Death Benefit _____

Secondary
Name _____ Birth Date _____ / _____ / _____ Gender □ M □ F
Street Address _____
City _____ State _____ Zip _____ Phone (_____) _____ - _____
Relationship to Employee _____ % Death Benefit _____

Spouse Information *(If applying for Spouse coverage complete this section.)*

Name _____ Birth Date _____ / _____ / _____ Gender □ M □ F Relationship _____
Address (*if different than yours) Street* _____ City _____ State _____ Zip _____

Dependent Information *(If applying for Dependent coverage complete this section. Note children must be under age 26.)*

1
Name _____ Birth Date _____ / _____ / _____ Gender □ M □ F Relationship _____
Address (*if different than yours) Street* _____ City _____ State _____ Zip _____

2
Name _____ Birth Date _____ / _____ / _____ Gender □ M □ F Relationship _____
Address (*if different than yours) Street* _____ City _____ State _____ Zip _____

3
Name _____ Birth Date _____ / _____ / _____ Gender □ M □ F Relationship _____
Address (*if different than yours) Street* _____ City _____ State _____ Zip _____

Policy Information *(Check Plans, Options, Riders & Coverage Level in which you are interested or would like more information.)*

□ Short Term Disability (Elimination Period: □ 0/7 □ 0/14 □ 7/7 □ 7/14 □ 14/14 □ 30/30 □ 60/60 □ 90/90 □ 180/180)
(Benefit: Amount: □ 6 months □ 12 months □ 18 months □ 24 months) (□ Plus Rider □ Plus Rider HSA)
□ Accident Advantage (□ Option 1 □ Option 2 □ Option 3 □ Option 4) (□ Individual □ Husband/Wife □ Single Parent □ Family) (□ Additional Accidental Death)
(□ Plus Rider □ Plus Rider HSA)
□ Cancer Care (□ Preferred □ Select □ Classic □ Premier) (□ Initial Diagnosis □ Specified Disease □ Dependent Care)
(□ Individual □ Husband/Wife □ Single Parent □ Family)
□ Critical Care Protection (□ Option 1 □ Option 2 □ Option 3) (□ Building Benefit □ Recovery Rider) (□ Individual □ Husband/Wife □ Single Parent □ Family)
□ Hospital Choice (□ Option 1 □ Option H) (Benefit Amount: □ $500 □ $1000 □ $1500 □ $2000) (□ Ext ended Benefit Rider □ Hospital Stay/Surgical Rider)
(□ Individual □ Husband/Wife □ Single Parent □ Family) (□ Plus Rider □ Plus Rider HSA)
□ Whole Life (□ Whole $_____) (□ 10 Year Term Spouse Rider) (□ Child Rider)
□ Term Life (□ 10 Year Term $_____ □ 20 Year Term $_____ □ 30 Year Term $_____) (□ 10 Year □ 20 Year □ 30 Year Term Spouse Rider) (□ Child Rider)
□ Juvenile Life (□ Child 1 □ Whole □ Term □ 10K □ 20K □ 30K) (□ Child 2 □ Whole □ Term □ 10K □ 20K □ 30K) (□ Child 3 □ Whole □ Term □ 10K □ 20K □ 30K)
□ Dental (□ Essentials) (□ Orthodontic Rider) (□ Cosmetic Rider) (□ Individual □ Husband/Wife □ Single Parent □ Family)
□ Vision (□ Level 1 □ Level 2 □ Level 3) (□ Individual □ Husband/Wife □ Single Parent □ Family)