

Good Value From People You Can Trust®



Co-operators Group Life Insurance Company
Group Premium Administration Department

Group No. _____
Account No. _____
PID No. _____
Effective Date _____

GROUP INSURANCE DECLINE CARD

I,
(Name of Employee)

employed by
do not wish to apply for insurance under the Group Policies offered by my employer (as indicated below).

- | | |
|---|--|
| <input type="checkbox"/> All Coverages | <input type="checkbox"/> Dental * |
| <input type="checkbox"/> Long Term Disability | <input type="checkbox"/> Extended Health |

Name of Insurer _____

Reason _____

I understand that if I wish to apply for this insurance at a later date, I will be required to furnish, at my own expense, evidence of my insurability satisfactory to the Insurance Companies.

* I understand that if I wish to apply for Dental Insurance at a later date, I and/or my eligible dependents will be restricted to first year benefit limits, as outlined in the group policy.

.....
(Signature for Employer) (Signature of Employee)

Date Signed

GL 112 (11/96)

THIS CARD TO BE FORWARDED TO ***the co-operators***

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