



## TO ALL FULL-TIME EMPLOYEES:

*We are offering additional Life Insurance to you and your family.  
We are making this available on a group basis.  
Everyone who is actively at work is eligible to participate.*

### THE ADVANTAGES OF THE INTEREST SENSITIVE WHOLE LIFE / 20 YEAR TERM LIFE ARE:

- 1) **Affordable protection**  
Coverage issued to everyone at standard rate (based on age).
- 2) **Guaranteed Issue Amounts**  
Coverage issued if you are actively at work as an employee, one question for your spouse, no questions for your children.
- 3) **Level Premium**  
Premiums do not increase.
- 4) **Level Death**  
Whole life death benefit is guaranteed to age 100.
- 5) **Cash Value Accumulation**  
Policy not only provides you with death benefit, but also cash value that earns tax-deferred interest.
- 6) **Payroll Deducted**  
Your premiums will be deducted from your check.
- 7) **Portability**  
You can take coverage with you for the same cost if you leave current employer.
- 8) **20-Year Double Indemnity**  
The whole life death benefit is doubled for the first 20 years of enrollment. (Available between 18 and 55 years of age.)
- 9) **Advance Benefit Option**  
Allows the policyholder to request an advance on the death benefit up to 50 percent while living if diagnosed with a terminal illness.

\* Please read over information and fill out the application if you are interested in participating.  
If you are not interested in participating, please sign the waiver section.

**Please return by May 1, 2008.**

A representative will be in contact with you.

**If you have any questions, please call Priscilla or Cassie at 1-800-877-4755 or 985-853-1080.**  
effective until after Evidence of Insurability is submitted, coverage can be denied. I understand that if a physical examination for further medical information is required, it will be at my own expense.



# WHOLE LIFE / 20 YEAR TERM ENROLLMENT FORM

## LIFE INSURANCE

Employee Name \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

State of Birth \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Occupations \_\_\_\_\_ Full Time Employment Date \_\_\_\_\_ Monthly Salary \_\_\_\_\_ Are you actively at work? \_\_\_\_\_

Home phone # \_\_\_\_\_ Work phone # \_\_\_\_\_ Cell phone # \_\_\_\_\_

Please select the three weekly premium options below by placing an "X".  
(Please "X" box for Spouse & Children).

**EMPLOYEE**     \$4.50                       \$7.50                       \$15.00  
Non-Tobacco  
Tobacco

**SPOUSE** (If not the same age as spouse, appropriate amount will be issued)  
Check     Yes     No                      \$4.50  
Non-Tobacco  
Tobacco

**CHILDREN** - \$10,000. Coverage on all dependent children under the age of 24 years old.  
Check     Yes     No                      \$1.16

\_\_\_\_\_  
Signature of Applicant Accepting Coverage

\_\_\_\_\_  
Date

### WAIVER DECLINING COVERAGE

I understand that if I desire to participate in the program at some future date, my coverage or my dependent's coverage will not be effective until after Evidence of Insurability is submitted, coverage can be denied. I understand that if a physical examination for further medical information is required, it will be at my own expense.

\_\_\_\_\_  
Signature of Applicant Waiving/Declining Coverage

\_\_\_\_\_  
Date