

Globe Life And Accident Insurance Company
Administrative Office: Globe Life Center, Oklahoma City, Oklahoma 73184
 Group Enrollment Form for Accidental Death Policy

Benefit Amount
\$3,000
 (\$3,000 spouse, \$1,000 each child)

Annual Mode of Premium

Payment Type
 Send Premium Notice
 Automatic Payment Plan
 Day of the Month to Draft Bank (01-28) _____

1. Proposed Insured/Applicant: _____							
First		Middle		Last			
2. Mailing Address: _____							
Street		City		State		Zip	
3. Age Last Birthday _____		4. Date of Birth: ____/____/____		5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female			
6. Home Telephone _____			Work Telephone _____				
Area Code		Number		Area Code		Number	
7. Social Security Number _____				8. Email Address _____			
9. Beneficiary			Relationship				
10. Proposed Insured's Spouse				Social Security Number		Date of Birth	
First		Middle		Last		____/____/____	
11. Child's Name				Social Security Number		Date of Birth	
First		Middle		Last		____/____/____	
A.				____/____/____		____/____/____	
B.				____/____/____		____/____/____	
C.				____/____/____		____/____/____	
D.				____/____/____		____/____/____	
E.				____/____/____		____/____/____	
F.				____/____/____		____/____/____	

Is the insurance applied for intended to replace or change any coverage now in force with this or any other company? If "Yes," comply with the application Replacement Regulation or Rule. Yes No

DECLARATION AND AUTHORIZATION

I hereby declare that the statements recorded above are true and complete to the best of my knowledge and belief with respect to any proposed insured. I agree that: (1) no policy will be binding upon the Company unless upon its date of issue and delivery each proposed insured is alive; (2) no agent has authority to accept risks or make or change contracts or waive the Company's rights or requirements. I understand and agree that the Company reserves the right during the first year the policy is in force, to restrict beneficiaries to designations acceptable to the Company. Except with respect to a minor child of mine, this application is made with the knowledge and consent of the proposed insured.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement is guilty of insurance fraud, which is a crime punishable by fine or imprisonment.

 Date Application State Agents' Signature Agents' Writing Number

 Signature of Proposed Insured/Applicant
 GLG-AP (41)