Dependent Life

Group Insurance Application

Greater Georgia Life
Atlanta, Georgia 30302

(1) Group Number	(2) Location No.

(3) Last Name   First   Initial   **(4) Social Security No.**   **(5) Date of Birth** Mo. Day Yr.   **(6) Date of Hire** Mo. Day Yr.
☐ Mr.
☐ Ms.

(7) Home Address   City   State   Zip Code

(8) Occupation or Position   (9) Employer Name
Bulloch County Board of Commissioners

(10) Effective Date Mo. Day Yr.

(12) Types and Amounts of Coverage Desired:
☐ Life _____
☐ Accidental Death and Dismemberment _____
☐ Dependent Life _____
☐ Short Term Disability _____
☐ Long Term Disability _____
☐ Supplemental Life _____

(11) Benefit Class

(13) Earnings
$ _____
☐ Hourly
☐ Weekly
☐ Biweekly
☐ Monthly
☐ Annual

(14) Beneficiary: Last Name – First Name – Initial   Relationship   Date of Birth

(15) I hereby apply for the amounts of coverage for which I am or may become eligible under my Employer's insurance program underwritten by GREATER GEORGIA LIFE INSURANCE COMPANY. I authorize the deduction by my employer from my earnings of amounts sufficient to cover my contributions, if any, toward the premium for such insurance. I am an active full-time employee working at least 30 hours each week for my Employer.

Signature _____   Date _____   Witness _____

82-M-A2

Complete ALL fields below with your dependent(s) information.

Dependent Name	Birthdate	Social Security #	Relationship (spouse/ child)