

**ENROLLMENT CARD**

POLICY NUMBER

SOCIAL SECURITY  
NUMBER

NAME OF SPONSORING  
ORGANIZATION

FIRST NAME

MIDDLE INITIAL

LAST NAME

STREET

CITY

STATE

ZIP CODE

DATE OF BIRTH (Month, Day, Year)

AMOUNT OF PRINCIPAL SUM

PREMIUM

EFFECTIVE DATE (LEAVE BLANK)

Do you wish to enroll  
in the Family Plan

Yes

No

You will be the Beneficiary for Spouse and Dependent Children Coverage

BENEFICIARY  
(FIRST NAME, MIDDLE INITIAL, LAST NAME)

ADDRESS  
(STREET, CITY, STATE)

RELATIONSHIP

NOTE: If the beneficiary is someone other than the spouse of the Insured, the spouse of the Insured must join in the completion of this enrollment card, if the Insured lives in Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, Wisconsin or any other community property state.

I understand the Insurance requested will not become effective unless I am performing all of the usual duties of my occupation on the Effective Date of the Insurance

Date

Your Signature

Your Spouse Signature (if required)

GERBER LIFE INSURANCE COMPANY

GER-PA-20-EC