

CLEAT BENEFIT PLAN & TRUST ADMINISTERED BY EMPLOYER PLAN SERVICES, INC.

Employer Name				Group No. 1053	Dept. No.	Location
Employee Last Name			First Initial	Social Security No.		
Street Address				City	State	Zip
Employee Date of Birth (Mo.) (Day) (Yr.)	<input type="checkbox"/> Single <input type="checkbox"/> Married	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Is Vision Insurance Requested? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is Dependent Insurance Requested? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>If Yes, Complete Dependent Information Section on Back.</small>		
ACCIDENTAL DEATH & DISMEMBERMENT PLAN <input checked="" type="checkbox"/> MEMBER & DEPENDENT				AMOUNT OF MEMBER'S PRINCIPAL SUM \$13,000.00		
Beneficiary Last Name			First Initial	Relationship		
Primary:						
Contingent:						
The member will be the beneficiary for the insurance of his dependents.						
I hereby apply for the amount and plan of insurance provided by the CLEAT BENEFIT PLAN & TRUST.						
Date Signed		Signature of Member				

I understand all eligible dependents to be covered must be listed on the reverse side of this form.
Employer Plan Services, Inc. 2180 North Loop West, Suite 400 Houston, Texas 77018

DEPENDENT INFORMATION

I understand all eligible dependents to be covered must be listed below. Further, I understand if my eligible dependents are covered by another group plan, I must complete the "OTHER COVERAGE" section below.

LAST NAME	FIRST	BIRTHDATE	SEX	RELATIONSHIP	OTHER COVERAGE	
					EMPLOYER	INSURANCE CARRIER
				SPOUSE		

I understand that should I decline to apply now for dental or vision coverage for my eligible dependent(s) and if I apply for such coverage at a later date, benefits will not be payable for any dental or vision expenses incurred during the 12 month period immediately following the effective date of such coverage. And I understand I will have to pay for the dental and vision coverage during this period.

Signed _____ Date Signed _____