J. J. STANIS and COMPANY, INC.
377 Oak Street · Suite 406
Garden City · New York 11530

EXCESS MAJOR MEDICAL ENROLLMENT CARD
(Please Print All Information)

Phone: (516) 465-3900
Fax: (516) 465-3920

POLICY HOLDER: _____ **OCCUPATION:** _____

INSURED NAME: (LAST) _____ **(FIRST)** _____

HOME ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

DATE OF BIRTH: _____ **SEX:** ☐ **MALE** ☐ **FEMALE**

SOCIAL SECURITY NUMBER: _____ **DATE OF EMPLOYMENT:** _____

ANNUAL SALARY: _____ **HOURS WORKED WEEKLY:** _____

MARITAL STATUS: ☐ **SINGLE** ☐ **MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐ **SEPARATED**

INFORMATION FOR DEPENDENTS

Do you now have eligible dependents? ☐ Yes ☐ No If yes, are they to be included in this plan? ☐ Yes ☐ No (If yes, please list your dependents below.)

FIRST NAME	DATE OF BIRTH MO DAY YR				FIRST NAME	DATE OF BIRTH MO DAY YR			
				☐ SPOUSE					☐ CHILD
				☐ CHILD					☐ CHILD
				☐ CHILD					☐ CHILD

I AM APPLYING FOR ☐ **INDIVIDUAL OR** ☐ **FAMILY COVERAGE / DATE OF MARRIAGE** _____

ELIGIBILITY: In order to be eligible for Excess Medical/Rehabilitation Insurance, you must be a participant in the empire N.Y. State Government Employee Health Insurance program through either you or your spouse's employer. Check one: ☐ Own ☐ Spouse's

☐ **REQUEST TO PARTICIPATE** **(CHECK ONE)**

I hereby request the policy holder to arrange to issuance of group insurance to which I am entitled, or to which I may be entitled, and I authorize my employer to make the periodic deductions, as applicable, from my earnings as my contributions toward the cost of insurance.

Signed _____
Signature of Employee

Date _____

Reason for refusing coverage: _____

☐ **WAIVER OF INSURANCE**

I do not wish to participate in this insurance program offered through my employer, and I understand that evidence of insurability satisfactory to the insurance company may be required if I desire to participate in the plan at a later date.

Signed _____
Signature of Employee

Date _____

PRIMARY BENEFICIARY:_____

_____ RELATIONSHIP_____

ADDRESS:_____

CONTINGENT BENEFICIARY:_____

_____ RELATIONSHIP_____

ADDRESS:_____

If more than one beneficiary is named, the death benefit, unless otherwise provided herein, will be paid in equal shares to the designated beneficiaries who survive the employee. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.