Metro Atlanta Financial Group

Group number: _____ Requested Effective Date: _____/_____/_____

Disability Application Form

Instructions: Please complete boxes outlined in **RED.**

A: Personal Information

Last Name: _____ Middle Initial: _____ First Name: _____

Date of Birth: ____/____/____ Social Security Number: _____

Street Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone Number: _____ E-mail Address: _____

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed

Gender: ◯ Male ◯ Female

Occupation: _____ Date of Hire: ____/____/____

Hours: _____ Salary: _____

Is the applicant currently a smoker? ◯ Yes ◯ No

Has the applicant used any tobacco products in the past 12 months? ◯ Yes ◯ No

B: Acknowledgement of Coverage and Signature

Name Printed: _____

Signature: **X** _____ Signature Date: ____/____/____