ACTION EXPEDITING

Group number: _____

Supplemental Life 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:

B: Calculate Weekly Cost

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.0323	0.0323	0.0323	0.0485	0.0762	0.1223	0.1223	0.2054	0.3392	0.4523	0.7062	2.115

To calculate Weekly Cost, please use following formula:

_____ ÷ $1,000 = _____ x _____ = $ _____
Life Benefit Amt — Rate — Weekly Cost

◯ I elect to **purchase** $_____ of life coverage.
◯ I elect to **continue** my current life coverage.

C. Beneficiary Information

Primary Beneficiary

Last Name: Middle Initial: First Name:
Social Security Number: Percentage of Benefit:
Gender: ◯ Male ◯ Female Date of Birth: ___/____/_____

Last Name: Middle Initial: First Name:
Social Security Number: Percentage of Benefit:
Gender: ◯ Male ◯ Female Date of Birth: ___/____/_____

Contingent Beneficiary

Last Name: Middle Initial: First Name:
Social Security Number: Percentage of Benefit:
Gender: ○Male ○Female Date of Birth: ___/___/_____

Last Name: Middle Initial: First Name:
Social Security Number: Percentage of Benefit:
Gender: ○Male ○Female Date of Birth: ___/___/_____

C. Acknowledgement of Coverage and Signature

Name Printed:

Signature: Signature Date: ___/___/_____