



# THERMOCOAX

Group number: \_\_\_\_\_

## 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: Beneficiary Information

#### Primary Beneficiary:

Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_  
Percentage of Benefit: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Gender: Male Female

Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_  
Percentage of Benefit: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Gender: Male Female

#### Contingent Beneficiary:

Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_  
Percentage of Benefit: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Gender: Male Female

Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ First Name: \_\_\_\_\_  
Percentage of Benefit: \_\_\_\_\_ Social Security Number: \_\_\_\_\_  
Gender: Male Female

### C: Acknowledgement of Coverage and Signature

Name Printed: \_\_\_\_\_

Signature: \_\_\_\_\_

Signature Date: \_\_\_\_/\_\_\_\_/\_\_\_\_