

Application Form

ASSOCIATION 4000 ENROLLMENT FORM

Last Name:	First Name
Address:	Beneficiary:
City:	State: Zip Code:
[] Male [] Female DOB:	SS#
Home/Cell Phone: ()	Email:

DEPENDENT INFORMATION

NAME	GENDER	SS#	DOB	RELATIONSHIP

SIGNATURE:	DATE:
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PLEASE CHECK BELOW THE PRODUCT YOU ARE ENROLLING FOR:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Short Term Disability
<input type="checkbox"/> Single <input type="checkbox"/> Family | <input type="checkbox"/> Long Term Disability
<input type="checkbox"/> Single <input type="checkbox"/> Family | <input type="checkbox"/> AD&D
<input type="checkbox"/> Single <input type="checkbox"/> Family
<input type="checkbox"/> 250,000 <input type="checkbox"/> 200,000 <input type="checkbox"/> 150,000 <input type="checkbox"/> 100,000 <input type="checkbox"/> 50,000 | <input type="checkbox"/> Term Life Insurance
<input type="checkbox"/> Single <input type="checkbox"/> Family
<input type="checkbox"/> 5,000 <input type="checkbox"/> 10,000 <input type="checkbox"/> 15,000 |
|---|--|---|---|

RETURN TO: **MARKETING BENEFITS, INC.**
P.O. BOX 1459
ORANGE BEACH, AL 36561

Tel: (800) 811-1600 Fax: (251) 974-3233

WRITING AGENT
 Name _____
 Address _____

 Email _____

GENERAL AGENT