Group Disability Insurance Enrollment Form
Kanawha Insurance Company

KMG AMERICA
KANAWHA INSURANCE COMPANY

Kanawha Insurance Company (Hereafter the "Company")

☐ Long Term Disability ☐ Buy-Up _____%	☐ Short Term Disability ☐ Buy-Up _____%	
Name of Policyholder		Policy No. (if known)
Name of Eligible Person (Last, First, MI)		Social Security No.
Your Home Address (Street, City, State, ZIP)	Home Telephone ( )	Date of Birth
	Work Telephone ( )	Gender (Check one) Male ☐ Female ☐
Job Title	Job Location	
Date of Hire	Earnings $_____/_____ Per Period	
No. Hours worked per week	Employment Status (Check one) ☐ Active ☐ COBRA ☐ Retiree	

Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be subject to prosecution and punishment for insurance fraud.

All statements in the Enrollment Form and other information provided to the Company for the purpose of underwriting insurance under the Policy will be deemed representations and not warranties.

I REPRESENT that the statements in this Enrollment Form and other information provided to the Company for the purpose of underwriting insurance under the Policy, are complete and true to the best of my knowledge and belief.

I UNDERSTAND THAT insurance under the Policy is effective when the requirements are met as stated in the Effective Date of Insurance provision of the Policy.

I authorize deduction be made from my wages and the total amount deducted for premium be remitted to Kanawha Insurance Company.

Signature _____ _____
Applicant Date

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