J. J. STANIS and COMPANY, INC.
377 Oak Street · Suite 406
Garden City · New York 11530

NON-CONTRIBUTORY LONG TERM DISABILITY ENROLLMENT CARD

(Please Print All Information)

Phone: (516) 465-3900
Fax: (516) 465-3920

POLICY HOLDER:_____ OCCUPATION:_____

INSURED NAME: (LAST)_____ (FIRST)_____

HOME ADDRESS:_____ CITY:_____ STATE:_____ ZIP:_____

DATE OF BIRTH:_____ SEX: ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER:_____ DATE OF EMPLOYMENT:_____

ANNUAL SALARY:_____ HOURS WORKED WEEKLY:_____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

☐ REQUEST TO PARTICIPATE (CHECK ONE)

Signed _____
Signature of Employee

Date _____

☐ WAIVER OF INSURANCE

I do not wish to participate in this insurance program offered through my employer, and I understand that evidence of insurability satisfactory to the insurance company may be required if I desire to participate in the plan at a later date.

Signed _____
Signature of Employee

Date _____

J. J. STANIS and COMPANY, INC.
100 Jericho Quadrangle • Suite 101
Jericho • New York 11753

NON-CONTRIBUTORY LIFE ENROLLMENT CARD

(Please Print All Information)

Phone: (516) 465-3900
Fax: (516) 465-3920

POLICY HOLDER: _____ OCCUPATION: _____

INSURED NAME: (LAST) _____ (FIRST) _____

HOME ADDRESS: _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH: _____ SEX: ☐ MALE ☐ FEMALE

SOCIAL SECURITY NUMBER: _____ DATE OF EMPLOYMENT: _____

ANNUAL SALARY: _____ HOURS WORKED WEEKLY: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED

PRIMARY BENEFICIARY: _____

_____ RELATIONSHIP _____

ADDRESS: _____

CONTINGENT BENEFICIARY: _____

_____ RELATIONSHIP _____

ADDRESS: _____

If more than one beneficiary is named, the death benefit, unless otherwise provided herein, will be paid in equal shares to the designated beneficiaries who survive the employee. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.

☐ REQUEST TO PARTICIPATE (CHECK ONE)

Signed _____
Signature of Employee

Date _____

☐ WAIVER OF INSURANCE

I do not wish to participate in this insurance program offered through my employer, and I understand that evidence of insurability satisfactory to the insurance company may be required if I desire to participate in the plan at a later date.

Signed _____
Signature of Employee

Date _____