

**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)

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

Signed \_\_\_\_\_  
Signature of Employee

Date \_\_\_\_\_

Date \_\_\_\_\_