Master Policy # _____
Effective Date : _____

MB Life
INSURANCE CORPORATION
ENROLLMENT FORM

Enrollment # _____

Name _____ Nationality _____
Address _____ Date of Birth _____ Age _____
_____ Place of Birth _____
Zipcode _____ Status: [ ] Single [ ]Married [ ]Widow(er) [ ]Separated Sex : [ ] F [ ] M
Employer / Association _____ Date Employed/Membership _____
Address _____ Zipcode _____ Mailing Address: [ ]Home [ ]Office
Tel/Mobile Nos. _____ / _____ Email Address _____
Occupation _____ Class/Level _____ Plan _____ Premium P _____

DESIGNATED BENEFICIARY (IES) / DEPENDENT (S)

BENEFICIARY (IES)	DEPENDENT (S) (IF THIS COVERAGE IS PROVIDED FOR)	Date of Birth	Age	Relationship

HEALTH DECLARATION

I hereby declare that during the past 5 years:

	YES	NO
a) I have not consulted any doctor for medical treatment nor have I been confined in a hospital, clinic or similar institutions.	[ ]	[ ]
b) I have not been advised that I have heart trouble, high blood pressure, cancer, diabetes, epilepsy, tuberculosis, Acquired Immune Deficiency syndrome (AIDS), AIDS Related Complex(ARC), or AIDS related condition.	[ ]	[ ]
c) I am not aware of any imppairment in my health or physical condition.	[ ]	[ ]
d) I am now in good health.	[ ]	[ ]
For Female Applicant: I am not pregnant. If pregnant, how many months? _____	[ ]	[ ]

No medical or physical examination shall be required although the Company reserves the right to require evidence of insurability.

EXCEPTIONS: Please indicate details of any NO answer.

_____ Date Signed

_____ Signature of Employee over Printed Name

Schedule of Benefits: (For Home Office use only)

Insureds	Amount of Insurance	SUPPLEMENTARY BENEFITS				
		AD & D				
Employee/Member						
Spouse/Parent(up to64 yrs)						
Children/siblings (1-20 yrs)						

AMENDMENTS/CHANGES
(For Home Office use only)

Effective Date								
Salary								
Amount of Insurance								
Other changes:								

Note: A written request is required to effect an amendment /change.