PROHAB THERAPY SPECIALIST
PRD AUTHORIZATION

Name: _____ Sex: __M__F Social Security Number: _____

Mailing Address: _____ City: _____ St: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Height: _____ Weight: _____

Date of Birth: _____ Date of Hire: _____ Job Title: _____ *Mother's Maiden Name:_____

Primary Beneficiary: _____ Relationship: _____ Email: _____

Complete For All Dependents (If coverage is requested)						
	Height	**Weight**	**SS#**	**Date of Birth**	**Age**	**Sex**
SPOUSE						
CHILDREN						

BI-WEEKLY DEDUCTIONS			MONTHLY PREMIUM AMOUNTS (FOR HOME OFFICE)			
					Deduction Date	**Bill Date**
1.	**Permanent Life - Transamerica**	**$**	**Monthly Perm Life Prem**	**$**		
2.	**Dental – Met Life**	**$**	**Monthly Dental Prem**	**$**		
3.	**Vision – Met Life**	**$**	**Monthly Vision Prem**	**$**		
	Total Deductions	**$**	**Total Monthly Premium**	**$**		

_____ _____

Date **Employee Signature of Authorization**

WAIVER OF COVERAGE

I have been offered the opportunity to participate in my employer's Employee Benefit Program and I decline. I understand that if I want to participate later, I may have to furnish evidence of insurability.

_____ _____

Date **Employee Signature of Declination**

- Permanent Life – If purchased, electronic signature includes last 4 digits of your social security number plus two digit month of birth plus your mother's maiden name. (example: 557902peddy)
- Permanent Life – If coverage is purchased on spouse Transamerica needs: Date of Marriage_____

State of Marriage_____