Please Fax your completed form to 985-871-1855.

Enrollment Form for Employee Life Insurance Plan

Dealer Account	Social Security Number	Date of Birth	Sex	Effective Date
		Mo. Day Year	M F	

Last Name of Enrollee	First Name (in full)	Initial	Dependent Coverage	Employee Class
			Yes No	

Employer (Full Name of Dealership)	Job Title	Amount of Insurance

Dealership Address (City, State and Zip Code)	Are you now an active employee of the above dealership? (1000 hours per year) Yes No
Name of Beneficiaries (Ex.: Write Helen Louise Jones "Wife" not Mrs. H.L. Jones) (Relationship)	Have you been hospitalized or had surgery within the last 365 days? (If yes, show details below) Yes No

If Dependent Coverage was requested, please list your dependents below: (If more than 6 dependents, please attach a separate page.)

	Dependent Name	Date of Birth Mo. Day Year	Type of Dependent (Child or Spouse)
1			
2			
3			
4			
5			
6			

I declare that the statements and answers are complete and true and understand that they are the basis for providing insurance under a policy(ies) issued by Prudential Insurance Company of America to NADIT. I understand that I may be required to satisfactorily complete a physical examination prior to approval of this application. Also, I hereby authorize my employer to make the necessary deduction from my wages or salary for the contributions of any required of me for the insurance.

Signature of enrollee _____ Date signed _____

NADA Insurance Administrators
P.O. Box 998 • Covington, LA 70434 • 1-888-461-6232 - • Fax (985) 871-1855