

Group Enrollment or Change Form

(Please print or type in Black ink.)

<input type="checkbox"/> New Employee	<input type="checkbox"/> Declination	<input type="checkbox"/> Class or Salary Change	Group # _____
<input type="checkbox"/> Beneficiary Change	<input type="checkbox"/> Change of Name	<input type="checkbox"/> Termination Date: _____	Class _____
<input type="checkbox"/> Dependent Status Change (Indicate reason _____)			Dept/Location _____
<input type="checkbox"/> Reinstatement (Complete Date of Rehire as Employment Date)			Eff Date _____

SECTION 1 - APPLICANT INFORMATION

Employee Legal Name (First, M.I., Last)				For Name Change, Give Prior Last Name	
Home Address		City	State	Zip	Telephone No.
Social Security #		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Marital Status
Occupation		Hours worked weekly		Date Employed Full-time	
Employer's Name				Salary \$ _____ <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	

SECTION 2 - Complete this Section if applying for Optional Coverage(s). Evidence of Insurability (EOI) may be required when applying for these coverage(s).

	Add	Delete	Indicate Date of: Marriage/Divorce _____ Birth of Child _____			
Basic Life/AD&D	Employer Paid		Dependents to be Covered	Relationship	Birthdate	SSN
Voluntary Life / AD&D (Employee)	<input type="checkbox"/> <small>indicate below</small>	<input type="checkbox"/>				
Voluntary Life / AD&D (Spouse)	<input type="checkbox"/> <small>indicate below</small>	<input type="checkbox"/>				
Voluntary Life / AD&D (Child/Children)	<input type="checkbox"/> <small>indicate below</small>	<input type="checkbox"/>				
Voluntary Life / AD&D Benefit Election (Employee)	Voluntary Life / AD&D Premium (Employee)		Voluntary Life / AD&D Benefit Election (Spouse)	Voluntary Life / AD&D Premium (Spouse)	Voluntary Life / AD&D Benefit Election (Child)	Voluntary Life / AD&D Premium (Child)
					Voluntary Life/AD&D Total Premium:	

SECTION 3 - BENEFICIARY DESIGNATION /CHANGE Check if Change Only

This will revoke any existing beneficiary designations you may have for these benefits.

PRIMARY BENEFICIARY(IES) (Will receive proceeds if living at death of Employee):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

Total must equal 100% =

CONTINGENT BENEFICIARY(IES) (Will receive proceeds if Primary Beneficiary(ies) are not living):

Name (Last, First, MI)	Address	SSN	Birthdate	Relationship	Percentage

Total must equal 100% =

I represent that the information provided above is true and correct. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. For those coverages I have declined, I understand that if I choose to enroll at a later date, Evidence of Insurability may be required. If the Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay. **Warning** - It is or may be a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company or other person. Penalties may include imprisonment, fines, and a denial of insurance benefits in accordance with applicable state law.

_____ Date

_____ Signature of Employee