

**LIFE AND DISABILITY ENROLLMENT FORM**

Please type or print legibly

**Employer Section**

1 \_\_\_\_\_  
 Group Policy No. Employer Name

2 \_\_\_\_\_  
 Location Name Class

3 \_\_\_\_\_  
 Coverage Effective Date Occupation and Duties Waiting Period

**Employee Section**

4 \_\_\_\_\_  
 Employee SS# Date of Birth Date of Hire Date of Rehire

5 \_\_\_\_\_  
 Employee Last Name, First, MI

6 \_\_\_\_\_  
 Street Address

7 \_\_\_\_\_  
 City State Zip Code

8 \$ \_\_\_\_\_  
 Base Earnings Per

9 \_\_\_\_\_  
 Hours worked per week

Male  Single  Hourly  Active  
 Female  Married  Salaried  Retired

**All Coverage's May Not Be Available**

10	Coverage for	Self	Dependent	Amount	Contrib.	Non Contrib.	Declined
	Life	<input type="checkbox"/>		\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Accidental Death & Dismemberment	<input type="checkbox"/>		\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	LTD	<input type="checkbox"/>		\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	STD	<input type="checkbox"/>		\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Optional Life	<input type="checkbox"/>		\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Dependent Life	<input type="checkbox"/>	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

11 Beneficiary (ies) Designation (Your benefits will be paid first to the Primary Beneficiary (ies). If that person(s) is deceased, benefits will be paid to the Contingent Beneficiary (ies). Legal appointment of Guardian is required if minor is named as Beneficiary).

Primary Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_ SS# \_\_\_\_\_

Contingent Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_ SS# \_\_\_\_\_

12 **ACCEPT:** I request coverage under my employer's plan of benefits as indicated above. If applicable, I authorize my employer to deduct from my earnings, my contributions for the coverage(s) selected. I understand that with respect to coverage's I have declined, the carrier has the right to require evidence of insurability in order to consider any later request to change this decision and that my request may be denied. I am an employee in active employment working at the employer's regular place of business.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**DECLINE:** I hereby decline all coverage as offered by my Employer. I understand that the carrier has the right to require evidence of insurability in order to consider any later request to change this decision and that my request may be denied. I am an employee in active employment working at the Employer's regular place of business.

Signature \_\_\_\_\_ Date \_\_\_\_\_