

Group Enrollment or Change Form

(Please print or type in Black ink.)

<input type="checkbox"/> New Employee	<input type="checkbox"/> Declination	<input type="checkbox"/> Change of Name	Group # _____
<input type="checkbox"/> Beneficiary Change	<input type="checkbox"/> Class or Salary Change		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 Name (First, M.I., Last)				For Name Change, Give Prior Last Name	
Social Security #	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Employee's State of Residence	Marital Status	
Occupation	Date Employed Full-time	Hours worked weekly	Salary \$ _____	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	
Employer's Name	Do you have eligible dependent children? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you actively at work on the date of this application? <input type="checkbox"/> Yes <input type="checkbox"/> No		

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		Add	Delete
<input type="checkbox"/> Supp Life/AD&D	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Dependent Life Indicate Date of: Marriage/Divorce _____ Birth of Child _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> STD	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> LTD	<input type="checkbox"/>	<input type="checkbox"/>			

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. I hereby designate the above beneficiaries under this certificate and revoke the appointment of any existing beneficiary. If the Group Insurance Plan provides that any contributions be made by me, I authorize my employer to deduct them from my pay.

Warning: Any person who commits a fraudulent act may be guilty subject to fines and confinement in prison.

Declination – I do not wish to enroll in the Group Plan at this time and I understand that I will have to furnish evidence of insurability at my own expense if I apply at a later date.

_____ Date

_____ Signature of Employee

FOR HOME OFFICE USE - IF COVERAGE SUBJECT TO EOI, UNDERWRITING DECISION		Date Received Home Office
APPROVED EFFECTIVE:	DECLINED DATE:	
BY:	BY:	