ENROLLMENT/CHANGE FORM (Please Print In Ink or Type) Shaded area to be completed by Employer

Employer or Plan Name _____ ☐ Enrollment ☐ Late Enrollment ☐ Annual Re-enrollment ☐ Change

Employee Name (Last - First - Middle)	Social Security No.	Date of Birth Mo Day Yr	Sex ☐ Male ☐ Female	☐ Hourly ☐ Salaried ☐ Other

Home Address	Number	Street	City	State	Zip plus 4

If new ENROLLMENT, indicate:

Effective Date Mo Day Yr

Date waiting period began Mo Day Yr

Date of hire Mo Day Yr

If CHANGE, indicate:

Type of Change	Effective Date of Change
☐ Add Spouse _____ Marriage Date	
☐ Add Child(ren)	
☐ Drop Spouse	
☐ Drop Child(ren)	
☐ Change Name	
☐ Change Address	
☐ Change Beneficiary	
☐ Reinstate Coverage	
☐ Other (Describe below)	

_____

_____

_____

Indicate Coverage Now Applying For:

Medical Plan _____	☐ Individual	☐ Family	☐ None
Dental	☐ Individual	☐ Family	☐ None
Drug	☐ Individual	☐ Family	☐ None
Vision	☐ Individual	☐ Family	☐ None
Life/AD&D	☐ Individual		☐ None
Dependent Life		☐ Family	☐ None

If "None" is checked, a waiver form must be completed and signed.

DEPENDENTS List below spouse and unmarried dependent children covered under this plan

First	M. Initial	Last (If different from empl.)	Social Security #	Date of Birth	Relationship	M/F	Add	Drop	Resides in your home?
									☐ Yes ☐ No
									☐ Yes ☐ No
									☐ Yes ☐ No
									☐ Yes ☐ No
									☐ Yes ☐ No

NOTE: IF THERE IS A COURT ORDER OR DIVORCE DECREE FOR ANY OF THE ABOVE DEPENDENT(S), YOU MUST SUPPLY A COPY WITH THIS FORM

If you are requesting to continue dependent status due to incapacitation, check ☐ Yes and list the dependent name: _____
You must attach a statement which states the conditions, treatments, current and future prognosis for this dependent

OTHER COVERAGE INFORMATION

Does your spouse or any dependent have other health coverage? ☐ Yes ☐ No If yes, provide:

Name(s) of Covered Person(s) _____ Effective Date _____ Coverage Type ☐ Medical ☐ Dental ☐ Vision

Employer _____ NAME ADDRESS PHONE #

Claims Payor _____ NAME ADDRESS PHONE #

Are you or any enrolled dependents covered by Medicare as the result of disability? ☐ Yes ☐ No If yes: Medicare effective date Mo Day Yr

Name of covered person(s) _____

LIFE/AD&D BENEFICIARY INFORMATION

Your Death Benefits are to be paid to First Beneficiary(ies):			If First Beneficiary(ies) is not living at your death, benefits are to be paid to Second Beneficiary(ies)		
Name	Relationship	% of Benefits	Name	Relationship	% of Benefits

I hereby apply for group coverage for which I am or may become eligible under the above group program except those waived above and designate the above beneficiary to receive all proceeds payable upon my death under the group life insurance policy(ies) in effect on the date of my death which is either issued to or sponsored by my Employer. I authorize deductions, if any, from my compensation for my share of the cost of the coverages to which I become entitled. I reserve the right to change the beneficiary designation at any time with proper written notice. I understand that I must meet the eligibility requirements of the Plan and that completion of this enrollment form does not guarantee coverage under the Plan. I affirm that the information contained herein is correct and true.

Date _____ Employee Signature X _____

Date _____ Employer Representative Signature X _____

Location	Plan	Basic Life Insurance	AD&D	Supp. Life	LTD
		$ _____	$ _____	$ _____	$ _____