

Check all box(es) and complete all sections that apply. Return completed form to your Human Resources Department.

<b>MEMBER INFORMATION</b>	<b>Enrollment</b> <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Rehire/Reinstatement		<b>Change</b> <input type="checkbox"/> Add Dependent <input type="checkbox"/> Beneficiary Change		<input type="checkbox"/> Delete Dependent <input type="checkbox"/> Address Change		<input type="checkbox"/> Date of add/delete _____ <input type="checkbox"/> Name Change <input type="checkbox"/> Other _____				
	Group Name			Group Number			Division ID				
	Your Name (Last, First, Middle)			If name change, what was your former name?			Soc. Sec. No.				
	Your Address			City			State		Zip		
	Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female		Earnings \$		Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr				
	Date of Hire		Hours Worked Per Week		Job Title/Occupation						
	Check with your Human Resources Department about coverage options, Dependent eligibility, and Evidence Of Insurability requirements.										
<b>COVERAGE SECTION</b>	<b>1. Life Insurance</b> <input type="checkbox"/> Life <input type="checkbox"/> Life/AD&D Employer paid amount \$ _____ <input type="checkbox"/> Additional Life Employee requested amount \$ _____ <input type="checkbox"/> Voluntary Life <input type="checkbox"/> Voluntary Life/AD&D Employee requested amount \$ _____										
	<b>2. Dependents Life Insurance</b> <input type="checkbox"/> Spouse requested amount \$ _____ Spouse Name _____ Date of Birth _____ <input type="checkbox"/> Children requested amount \$ _____										
	<b>3. Accidental Death and Dismemberment (AD&amp;D) Insurance</b> <input type="checkbox"/> Employer paid AD&D <input type="checkbox"/> Voluntary AD&D Employee requested amount \$ _____										
	<b>4. Dependents Accidental Death and Dismemberment (AD&amp;D) Insurance</b> <input type="checkbox"/> Spouse requested amount \$ _____ <input type="checkbox"/> Children requested amount \$ _____										
	<b>5. Short Term Disability</b> <input type="checkbox"/> Base/Voluntary <input type="checkbox"/> Enhanced										
	<b>6. Long Term Disability</b> <input type="checkbox"/> Base/Voluntary <input type="checkbox"/> Enhanced										
	<b>7. Dental (see below)</b> <input type="checkbox"/> Base/Voluntary <input type="checkbox"/> High Plan										
<b>DENTAL</b>	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced Coverage requested for <input type="checkbox"/> Member, spouse and children <input type="checkbox"/> Member and spouse <input type="checkbox"/> Member only <input type="checkbox"/> Member and children (no spouse) Are you covered for Dental Insurance under another plan? Member <input type="checkbox"/> Yes <input type="checkbox"/> No Dependent(s) <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had Dental Insurance with us before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, last termination date _____										
	List dependents you wish to enroll or delete. Add sheet for additional dependents if needed.						Sex		Birth Date		
	Name (Last, First, Middle Initial)				Relationship		M	F	Mo.	Day	Yr.
<b>BENEFICIARY</b>	This designation applies to Coverage Section 1 coverage above. Unless specified otherwise on a separate sheet of paper, this designation will also apply to Coverage Section 3 coverage above. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further beneficiary information.										
	Primary – Full Name			Address			Soc. Sec. No.		Relationship	% of Benefit	
	Contingent – Full Name			Address			Soc. Sec. No.		Relationship	% of Benefit	
<b>SIGNATURE</b>	I wish to apply for insurance under the Group Insurance Plan, or to authorize the changes noted above. I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.										
	Member Signature Required						Date (Mo/Day/Yr)				

Human Resources Department – Retain for your records.

## Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated \_\_\_\_\_."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.