

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).

Dependent Life	Add <input type="checkbox"/>	Delete <input type="checkbox"/>	Indicate Date of: Marriage/Divorce _____ Birth of Child _____		
Supp Life	<input type="checkbox"/>	<input type="checkbox"/>	Dependents to be Covered	Relationship	Birthdate
Supp AD&D	<input type="checkbox"/>	<input type="checkbox"/>			
STD	<input type="checkbox"/>	<input type="checkbox"/>			
LTD	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<input type="checkbox"/>	<input type="checkbox"/>			
	<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. 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
------------	-----------------------------

Date Received - Home Office
