

Mark all boxes and complete all sections that apply. Return completed form to the address below.

APPLICANT	Your Name (Last, First, Middle)		Group Name School Administrators Special Services (SASS)		Group Number(s) 641419		
	Your Address		City		State	ZIP	
	Employer		Your Soc. Sec. No.	Work Phone No.		Home Phone No.	
	Employer Address			City		State	ZIP
LIFE	<input type="checkbox"/> New Coverage <input type="checkbox"/> Change in Coverage <input type="checkbox"/> I am a new member of the Association and never before eligible for membership.						
	Life Insurance						
	Member Life Coverage: Annual Salary \$ _____ Coverage Amount \$ _____ Rate Per \$1,000 _____ Spouse Life Coverage: <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 Coverage Amount \$ _____ Rate Per \$1,000 _____ Child(ren) Life Coverage: <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 If you have never been eligible for Association membership and apply for coverage within 90 days of becoming a member, you are guaranteed to be accepted for the Member Life Plan in the amount of 2x salary (coverage limited to \$200,000). Evidence of good health is required for any amount of Spouse Life coverage, but not for Child coverage.						
FAMILY MEMBERS TO BE INSURED	Member Name (Last, First, Middle)		Relationship Member	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	State of Birth	
	Spouse Name (Last, First, Middle)		Relationship Spouse	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	State of Birth	
	Name (Last, First, Middle)		Relationship	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	State of Birth	
	Name (Last, First, Middle)		Relationship	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	State of Birth	
	Name (Last, First, Middle)		Relationship	<input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth	State of Birth	
BENEFICIARY	<i>This designation applies to Member Life Insurance available through the SASS. Designations are not valid unless signed, dated, and delivered to the Plan Administrator during your lifetime. See page 2 for further information.</i>						
	Primary - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit	
	Contingent - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit	
CHANGE	Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.						
	<input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent		<input type="checkbox"/> Name Change		<input type="checkbox"/> Beneficiary Change		
Date of add/delete _____		Former name _____		<input type="checkbox"/> Other _____			
SIGNATURE	<input type="checkbox"/> I wish to make the choices indicated on this form. If electing coverage 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.						
	<input type="checkbox"/> I wish to make the choices indicated on this form. If electing coverage, I wish to be billed at my home on a quarterly basis to cover my contribution, if required, toward the cost of insurance. I understand that my contribution amount will change if my coverage or costs change.						
Member Signature Required				Date (Mo/Day/Yr)			
INSTRUCTIONS	Medical History Statement is required from the member if applying for more than guaranteed acceptance coverage and from the spouse for any amount of coverage. Check to see that the Enrollment Form and each Medical History Statement, if required, are signed before mailing to the Plan Administrator. Additional forms are available from the Plan Administrator.						
	Plan Administrator: Mestmaker and Associates, PO Box 2302, Bakersfield CA 93303 877.472.6722 Tel						

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.
- 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 any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer’s coverage under the Group Policy.