

To Be Completed By Human Resources

Group Number 000000	Division	Billing Category	Date of Employment
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To Be Completed By Applicant Apply for Coverage Beneficiary Change *Complete Beneficiary Section below.* Name Change
 Reinstatement Add or Delete Dependent Date of add/delete _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Your Address		City	State ZIP
Former Name (Last, First, Middle) <i>Complete only if name change</i>		Phone Number	
Employer Name ABC Company, Inc.		Job Title/Occupation	
Hours Worked Per Week	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year	

Coverage *Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.*

Life Insurance

Basic Life with AD&D (Employer Paid)
 Additional Life with AD&D requested amount \$ _____

Dependents Life Insurance

Spouse Life with AD&D requested amount \$ _____
 Spouse Name _____ Date of Birth _____
 Child(ren) Life with AD&D requested amount \$ _____

Short Term Disability

Voluntary STD

Long Term Disability

Voluntary LTD

Beneficiary *This designation applies to your Life and Accidental Death and Dismemberment Insurance available through your Employer. Unless specified otherwise on a separate sheet of paper, this designation will also apply to coverage available through your Employer. Designations are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.*

Primary – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. <i>if known</i>	Relationship	% of Benefit*
Contingent – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. <i>if known</i>	Relationship	% of Benefit*

***Total must equal 100%**

Return completed form to your Human Resources Department.

Signature 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.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____

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.

SAMPLE

Return completed form to your Human Resources Department.