Group Insurance Enrollment Form

ALL FIELDS MUST BE COMPLETED

Member's Full Name:* _____
(please print) First Middle Last

Home Address: * _____
Number Street City State Zip

Date of Birth:* _____/_____/_____ **Social Security #:*** _____

Telephone Number:* _____ **Email Address:*** _____

Term Life Insurance

- ☐ Basic Life Insurance_____
- ☐ Supplemental/Optional Life Insurance_____
- ☐ Supplemental/Optional Dependent Spouse _____
- ☐ Supplemental/Optional Dependent Child_____
- ☐ Accidental Death and Dismemberment (AD&D)_____

Disability Income Insurance

- ☐ Short Term Disability Benefits_____
- ☐ Long Term Disability Benefits_____

Beneficiary Designation*					
	Name	Date of Birth	Relationship to Member	% of Benefit	Last 4 of SS#
Primary					
Primary					
Primary					
			TOTAL (must equal 100%)		
Contingent					
Contingent					
Contingent					
*If more space is needed, use the back of this form			**TOTAL (must equal 100%)**		
*Designations are not valid unless signed, dated, and delivered to the plan administrator at the address listed above					

_____ _____
Member Signature Date