

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

MEMBER INFORMATION	<b>Enrollment</b> <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Rehire/Reinstatement		<b>Change</b> <input type="checkbox"/> Add Dependent <input checked="" type="checkbox"/> Beneficiary Change		<input type="checkbox"/> Delete Dependent <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <input type="checkbox"/> Other _____		<input type="checkbox"/> Date of add/delete _____		
	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				
COVERAGE SECTION	Check with your Human Resources Department about coverage options, Dependent eligibility, and Evidence Of Insurability requirements.								
	<b>1. Life Insurance</b> <input type="checkbox"/> Life <input checked="" 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 checked="" type="checkbox"/> Base/Voluntary <input type="checkbox"/> Enhanced								
	<b>7. Dental (see below)</b> <input type="checkbox"/> Base/Voluntary <input type="checkbox"/> High Plan								
DENTAL	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.								
	Name (Last, First, Middle Initial)				Relationship		Sex	Birth Date	
							M <input checked="" type="checkbox"/> F	Mo. Day Yr.	
BENEFICIARY	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	
SIGNATURE	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.