



ENROLLMENT FORM

INSTRUCTIONS: *Shaded portion to be completed by the Employer. The balance is to be completed by the employee. Print clearly in dark ink, sign the form, and return as instructed. Be sure to initial all changes.*

NAME OF EMPLOYER	GROUP / PLAN NUMBER	DATE OF HIRE / /
This form is being completed due to): <i>(Check all that apply)</i> <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> New Enrollee <input type="checkbox"/> Late Entrant**		EFFECTIVE DATE OF COVERAGE/CHANGE / /
<input type="checkbox"/> Address Change <input type="checkbox"/> Other: _____		

SECTION 1. Employee Information. *If additional space is required, complete and attach a separate sheet of paper (signed and dated).*

EMPLOYEE NAME <i>(last, first, middle initial)</i>	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	DATE OF BIRTH / /	SOCIAL SECURITY #	EMPLOYEE I.D. #
MARITAL STATUS	JOB TITLE OR OCCUPATION	ANNUAL SALARY	HOURS WORKED PER WEEK:	<input type="checkbox"/> ACTIVE FULL-TIME <input type="checkbox"/> ACTIVE PART-TIME
EMPLOYEE ADDRESS <i>(street address, city, state, zip code)</i>			TELEPHONE Work () Home ()	

SECTION 2. Coverage Selection

BASIC LIFE / AD&D	<input type="checkbox"/> Employee Elect Coverage <input type="checkbox"/> Employee Decline Coverage	Basic Dependent Life: Yes _____ No _____
SUPPLEMENTAL LIFE – Employee	<input type="checkbox"/> Employee Elect Coverage <input type="checkbox"/> Employee Decline Coverage	Amount Requested \$ _____
SUPPLEMENTAL LIFE – Spouse	<input type="checkbox"/> Spouse Elect Coverage D.O.B. ____/____/____ <input type="checkbox"/> Spouse Decline Coverage	Amount Requested \$ _____ Spouse
SUPPLEMENTAL LIFE – Child(ren)	<input type="checkbox"/> Child(ren) Elect Coverage <input type="checkbox"/> Child(ren) Decline Coverage	Amount Requested \$ _____

SECTION 3. Beneficiary Selection

(See back for Popular Beneficiary Designations <i>List one or more beneficiaries below.</i>	BENEFICIARY'S SOCIAL SECURITY #	RELATIONSHIP TO EMPLOYEE	BENEFICIARY'S DATE OF BIRTH	PERCENT OF BENEFIT <i>(MUST add to 100%)</i>
PRIMARY:				
SECONDARY:				

SIGN AND DATE BELOW

To the best of my knowledge and belief the information on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I am an active employee of the Employer shown above. I understand that the terms of the coverage for which I am enrolling are set forth in the Group Policy issued to my Employer. Also, subject to revocation by me by written notice to my Employer at any time, I authorize the required deduction (if any) from my wages for the insurance I have selected.

Employee's Signature	Date Signed / /	Signature or Name of Benefits Person	Date Signed / /
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POPULAR BENEFICIARY DESIGNATIONS

(A married woman should be designated by her first name, middle initial and last name. For example, Mary J. Smith, **not** Mrs. Thomas A. Smith.)

(If a beneficiary is not related to you by blood or marriage, “business associate”, “partner”, or other economic relationship should be inserted; otherwise, insert “non-relative”.)

1. One beneficiary only; Mary J. Smith, wife.

2. Two or more beneficiaries, equal amounts: William F. Smith, father,
Alice C. Smith, sister, and
Richard B. Smith, brother,
Equally or to the survivors equally, or to the survivor.

3. Unequal amounts: 50% to Mary J. Smith, wife, and
25% each to Alice C. Smith, sister, and
Richard B. Smith, brother,
the share of any deceased beneficiary to be
paid in equal shares to the survivors, or to the survivor.

4. Primary and contingent beneficiary: Mary J. Smith, wife, if living; otherwise the
children born of the marriage of the insured to
Mary J. Smith, equally, or equally to the
survivors, or to the survivor.

5. Trustee Beneficiary: The Trust Company of Smith, Illinois as trustee
under a Trust Instrument dated December 29,
1967.