

Check all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT	Your Name (Last, First, Middle)		Group Name		Group Number(s)	
	Your Address			City		State Zip
	Your Soc. Sec. No.		Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Job Title/Occupation						

COVERAGE SECTION	Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.					
	1. Life Insurance					
	<input type="checkbox"/> Life <input type="checkbox"/> Life with AD&D Employer paid amount \$ _____					
	<input type="checkbox"/> Additional/Optional Life <input type="checkbox"/> Additional/Optional Life with AD&D Your requested amount \$ _____					
	2. Voluntary Life Insurance					
	<input type="checkbox"/> Voluntary Life <input type="checkbox"/> Voluntary Life with AD&D Your requested amount \$ _____					
	3. Dependents Life Insurance					
	<input type="checkbox"/> Spouse requested amount \$ _____ Spouse Name _____ Date of Birth _____					
<input type="checkbox"/> Children requested amount \$ _____						
4. Accidental Death and Dismemberment (AD&D) Insurance						
<input type="checkbox"/> AD&D Employer paid amount \$ _____ <input type="checkbox"/> Voluntary AD&D Your requested amount \$ _____						
5. Supplemental Life Insurance Your requested amount \$ _____ Spouse requested amount \$ _____						
6. Short Term Disability <input type="checkbox"/> Employer Paid <input type="checkbox"/> Enhanced (Buy-up) <input type="checkbox"/> Voluntary STD						
7. Long Term Disability <input type="checkbox"/> Employer Paid <input type="checkbox"/> Enhanced (Buy-up) <input type="checkbox"/> Voluntary LTD						
8. Dental (See below) <input type="checkbox"/> Employer Paid <input type="checkbox"/> High Plan <input type="checkbox"/> Voluntary Dental						

DENTAL	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced						
	Coverage requested for <input type="checkbox"/> You, your spouse and children <input type="checkbox"/> You and your spouse <input type="checkbox"/> You only <input type="checkbox"/> You and your children (no spouse)						
	Are you covered for dental insurance under another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Are one or more dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No						
	List dependents to enroll or delete.		Sex	Date of Birth	List dependents to enroll or delete.		
	(Last name if different, First, Middle Initial)	M	F		(Attach sheet for additional dependents if needed.)	M	F
Spouse				Child 2			
Child 1				Child 3			

Dental Insurance Waiver: Contributory Dental Insurance
 The Dental Insurance coverage available to me and my Dependents has been explained to me and I do not want to enroll at this time. I understand that if I elect to enroll in the future, the Dental Insurance coverage may be subject to a Late Enrollment Penalty.
 I decline Dental Insurance for myself I decline Dental Insurance for one or more Dependents

This designation applies to coverage available through your Employer, if any, under Coverage Section 1 or 2 above. Unless specified otherwise on a separate sheet of paper, this designation will also apply to coverage available through your Employer, if any, under Coverage Sections 4 and 5 above. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.

Primary - Full Name		Address		Soc. Sec. No.	Relationship	% of Benefit
Contingent - Full Name		Address		Soc. Sec. No.	Relationship	% of Benefit

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 _____	

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)
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Human Resources Department - Complete this section. Retain form for your records.

Division ID	Billing Category	Date of Hire or Rehire	Hours Worked Per Week	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr
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