

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

MEMBER INFORMATION	Enrollment		Change	
	<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Delete Dependent	<input type="checkbox"/> Date of add/delete _____
	<input type="checkbox"/> Rehire/Reinstatement	<input type="checkbox"/> Beneficiary Change	<input type="checkbox"/> Address Change	<input type="checkbox"/> Name Change <input type="checkbox"/> Other _____
	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		

Check with your Human Resources Department about coverage options, Dependent eligibility, and Evidence Of Insurability requirements.

1. Life Insurance
 Life Life/AD&D Employer paid amount \$ _____ Additional Life Employee requested amount \$ _____
 Voluntary Life Voluntary Life/AD&D Employee requested amount \$ _____

2. Dependents Life Insurance
 Spouse requested amount \$ _____ Spouse Name _____ Date of Birth _____
 Children requested amount \$ _____

3. Accidental Death and Dismemberment (AD&D) Insurance
 Employer paid AD&D Voluntary AD&D Employee requested amount \$ _____

4. Dependents Accidental Death and Dismemberment (AD&D) Insurance
 Spouse requested amount \$ _____ Children requested amount \$ _____

5. Short Term Disability Base/Voluntary Enhanced

6. Long Term Disability Base/Voluntary Enhanced

7. Dental (see below) Base/Voluntary High Plan

DENTAL

Marital Status Single Married Divorced

Coverage requested for Member, spouse and children Member and spouse Member only Member and children (no spouse)

Are you covered for Dental Insurance under another plan? Member Yes No Dependent(s) Yes No

Have you had Dental Insurance with us before? Yes No If yes, last termination date _____

Name (Last, First, Middle Initial)	Relationship	Sex		Birth Date		
		M	F	Mo.	Day	Yr.

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)
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