

## EMPLOYEE GROUP TERM LIFE INSURANCE ENROLLMENT FORM

**PLEASE PRINT**

**COMPLETE IN PEN**

**DO NOT USE PENCIL**

### EMPLOYEE INFORMATION

Last Name	First Name	M I
Social Security Number	Telephone Number	
Address		
City	State	Zip
Sex	Date of Birth	Date of Hire
Job Class or Description		Work Telephone
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Name of Spouse		Date of Birth
Spouse Social Security #:		

### COVERAGES

<input type="checkbox"/> Group Term Life Insurance	<input type="checkbox"/> Dependent Life Insurance
<input type="checkbox"/> Accidental Death & Dismemberment Insurance	<input type="checkbox"/> Long Term Disability (if applicable)

### BENEFICIARY INFORMATION

Please list additional beneficiaries and portion % on reverse side

Beneficiary Name:		
Relationship & Age:	Portion	%
Beneficiary Phone Number:		
Beneficiary Address		
City	State	Zip

### CONTINGENT BENEFICIARY INFORMATION

Please list additional beneficiaries and portion % on reverse side

Beneficiary Name:		
Relationship and Age:	Portion	%
Beneficiary Phone Number:		
Beneficiary Address:		
City	State	Zip

### DEPENDENT INFORMATION

Please List All Dependents *(Continue on Reverse Side if Necessary)*

Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:
Name:	Relationship:	Date of Birth:

I hereby (1) request any Employee Benefit Group Life Insurance coverage(s) for which I am now or may become eligible for, and (2) designate the Beneficiary named on this form to receive the proceeds, if any, payable in the event of my death. I also understand that I may change beneficiaries, if I so choose, at any time in the future.

Signature of Employee \_\_\_\_\_ Date Signed \_\_\_\_\_