

**Basic Group Life
Enrollment/Change Form**



Please return completed form to your employer.

Section I. Employer Completes This Section

Group Number	Effective Date	Hire Date	Occupation/Job Title
Employee Name	Annual Salary	Life Class	Life/AD&D Amount
Source of Enrollment:	Open Enrollment <input type="checkbox"/>	New Hire <input type="checkbox"/>	Intercompany Transfer <input type="checkbox"/> Rehire <input type="checkbox"/>
Company Name	Company Address	City	State, Zip

Section II. Applicant Completes This Section

Last Name	First Name, M.I.	Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth
Mailing Address	City	State	Zip
Social Security Number	Home Phone Number	Work Phone Number	

Section III. Applicant Completes This Section For New Enrollment Purposes Only

Life Insurance Beneficiary (full name)	Beneficiary's Date of Birth	Relationship to Employee
I Am Applying for Coverage On:	Self Only <input type="checkbox"/>	Self & Eligible Dependents <input type="checkbox"/> (Available only if elected by Employer)

Section IV. Applicant Completes This Section For Changes To The Existing Life Insurance Coverage

Effective Date of All Changes:	Terminate Employee Life Coverage <input type="checkbox"/>	Add Dependent Life Coverage <input type="checkbox"/>	
	Terminate Dependent Life Coverage <input type="checkbox"/>		
Please Change To:	New Name	New Amount of Coverage	Other Changes
New Beneficiary Information:	Beneficiary's Name	Date of Birth	Relationship

I understand that if I am disabled and not able to be at work on the date life insurance (and dependent life insurance, if applicable) is to become effective, coverage will not take effect until I return to active employment and meet all of the policyholder's eligibility requirements. I represent to the best of my knowledge that the above information is true and I hereby authorize payroll deductions from my earnings for any contributions or fees as may be required to maintain my eligibility.

Applicant Signature: _____ Date _____

Employer Signature: _____ Date _____

Received	Verified	Data Entered By	Re-Enroll Dep. Numbers	Employee Number
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