

Life and Disability Income Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee.

Name of Employer/Plan Sponsor North American Division of Seventh-day Adventists		Group/Plan Number 67807-4	Account Number/Location	
Class/Occupation	Date of Hire (mm/dd/yyyy)	Annual Salary	Employment Status:	<input type="checkbox"/> Active Full-Time <input type="checkbox"/> Active Part-Time
This change is due to: (check all that apply) <input type="checkbox"/> Initial Eligibility Following Hire <input type="checkbox"/> Late Entrant* <input type="checkbox"/> Change in Coverage Amount <input type="checkbox"/> Other: _____				Effective Date of Coverage or Change:

**A late entrant is an individual who is first enrolling for supplemental or dependent life income coverage after the first available opportunity.*

Employee Information

Employee Name (last, first, middle initial)		Date of Birth (mm/dd/yyyy)	Social Security #	Employee I.D. #
Employee Address (street address, city, state, zip code)		Work Phone Number	Home Phone Number	<input type="checkbox"/> Female <input type="checkbox"/> Male

Disability Income Coverage

Monthly Income Benefits (LTD) <i>(Note: LTD coverage is employer provided.)</i>	<input checked="" type="checkbox"/> Elect Coverage – (Only Full-Time Employees are eligible for coverage.)
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Employee Life Insurance (Subject to a combined basic and supplemental plan maximum of \$850,000.)

Basic Life <i>(Note: Basic Life insurance is employer provided and only available to Full-time Employees.)</i>	<input type="checkbox"/> Standard Plan – Employee (\$100,000), Spouse (\$50,000), and Child(ren) (\$10,000) <input type="checkbox"/> Waive – I waive the Standard Plan and elect Plan A or B (Employee please see your Human Resources Representative for Plan A or Plan B enrollment form)
Supplemental Life	When you are initially eligible for Supplemental Life Insurance you can elect the Guaranteed Issue (GI) Limit of \$250,000 without Evidence of Insurability. Total Supplemental Life coverage up to \$750,000 in \$10,000 increments is available if you complete an Evidence of Insurability form subject to approval by ReliaStar Life. Minimum coverage amount is \$10,000.
Supplemental Life Election	<input type="checkbox"/> Elect: \$ _____ (<i>\$10,000 increments</i>) <input type="checkbox"/> Waive

Beneficiary Information *Designate your beneficiary(ies) below.*

Name of Beneficiary (last name, first, middle initial)		<input checked="" type="checkbox"/> Primary	Relationship to Employee	Benefit %
Address		Date of Birth	Social Security Number	Phone Number
Name of Beneficiary (last name, first, middle initial)		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Relationship to Employee	Benefit %
Address		Date of Birth	Social Security Number	Phone Number
Name of Beneficiary (last name, first, middle initial)		<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Relationship to Employee	Benefit %
Address		Date of Birth	Social Security Number	Phone Number

Dependent Spouse Life Insurance

Spouse Life	<p>If you are covered for Supplemental Life you can elect Dependent Spouse coverage.</p> <p>When you are initially eligible for Dependent Spouse coverage you can elect up to the Guaranteed Issue (GI) Limit of \$30,000 without Evidence of Insurability on your spouse.</p> <p>Total Dependent Spouse Life coverage up to \$250,000 in \$10,000 increments is available if your spouse completes an Evidence of Insurability form subject to approval by ReliaStar Life. Spouse coverage is limited to 100% of the employee's Supplemental Life coverage amount. Minimum coverage amount is \$10,000.</p>	
Spouse Name and Date of Birth	Spouse Name _____	Spouse Date of Birth _____
Spouse Life Election	<input type="checkbox"/> Elect: \$ _____ (<i>\$10,000 increments</i>) <input type="checkbox"/> Waive	

Note: The employee is the beneficiary for any Dependent Spouse insurance coverage.

Dependent Child(ren) Life Insurance

Child(ren) Life	<p>If you are covered for Supplemental Life you can elect Dependent Child(ren) coverage.</p> <p>When you are initially eligible for Dependent Child(ren) Life coverage you can elect from \$1,000 to \$25,000 in \$1,000 increments on your children from birth to less than 26 years without Evidence of Insurability. Child(ren) coverage is limited to 100% of the employee's Supplemental Life coverage amount. Minimum coverage amount is \$1,000.</p>	
Child(ren) Life Election	<input type="checkbox"/> Elect: \$ _____ (<i>\$1,000 increments</i>) <input type="checkbox"/> Waive	

Note: The employee is the beneficiary for any Dependent Child(ren) insurance coverage.

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee's Signature	Date Signed (<i>mm/dd/yyyy</i>)
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THIS IS NOT AN APPLICATION FOR INSURANCE.
It is an enrollment form for coverage under a group plan sponsored by your employer.