The Business Council INSURANCE FUND

# ENROLLMENT FORM

**Group No.** _____

**Employer:** _____

**Employee Name:** _____

Last First Middle

**Social Security No.** ____ / ____ / ____ **Date of Birth** ____ / ____ / ____ **Gender:** Male ☐ Female ☐

**Date Hired:** ____ / ____ / ____

**Annual Salary:** _____

**Please check applicable box.**

- ☐ **Life/AD&D**
- ☐ **Dependent Life**
- ☐ **LTD**
- ☐ **DBL/STD**

## BENEFICARY DESIGNATION

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, relationship and, if a minor, the age of that minor. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related." If you need assistance, contact Human Resources or your own legal counsel. Following are examples of the most common designations:

- Mary J. Doe, Wife (not Mrs. John Doe).
- Mary J. Doe, Wife, If living, otherwise to Joseph W. Doe, Son.
- Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter and Joseph W. Doe, Son , in equal shares or to the survivor.
- Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "1/3 to Mary Jones, Mother and 2/3 to Edith Jones, Wife."

| | Full Name | Address | Relationship | D.O.B. |
|---|---|---|---|---|
| **Primary** | | | | |
| | | | | |
| **Contingent** | | | | |
| | | | | |

The beneficiary for life insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employees Life Insurance may be changed upon written request.

## DEPENDENT LIFE INSURANCE

| Effective | | | Name of Eligible Dependents to be Covered* | Relationship | D.O.B. |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

• The term "dependent" is limited to the employee's spouse, unmarried children to age 19, and unmarried children from 19 to 25 who are registered full-time students, principally dependent upon the employee for maintenance and support, residing in the United States or Canada.

## Employee Statement

I understand that on the effective date of my insurance coverage, I must meet each of the following conditions: (a) I must be actively at work and able to perform all duties of my occupation;(b) I must be regularly working on a full-time basis at my employer's business establishment or at some other location to which my employer's business requires me to travel, and (c) I have completed any applicable waiting period.

I certify that I meet each of the above conditions and understand that I will not be covered otherwise. I authorize my employer to make deductions from my earnings, if contributions are required.

**Employee Signature** **Date** **Certified** **Employer Representative** **Date**

**Please do not write below - for Business Council purposes only**

**Eff. Date:** ____ / ____ / ____ (Month / Day / Year) **Amount of Insurance:** _____ **Monthly Salary:** _____ **DBL/STD:** _____