Group No. _________

Enrollment Form

☐ New Hire
☐ Name Change
☐ Beneficiary Change

Social Security #			Employer:

Employee Name: (Last, First, Middle)	Date of Birth			Gender	Date of Hire		
	Month	Day	Year	☐ M ☐ F	Month	Day	Year

Annual Salary	Occupation

Enrolling for the following coverages (check all that are applicable)

Ό Life/Accidental Death Personal Loss Ό Dependent Life Ό LTD Ό NYS-DBL Ό STD

Beneficiary 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 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 "1/2 to Mary Jones, Mother and 2/3 to Edith Jones, Wife."

	Full Name	Address	Relationship	Date of Birth	%
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*	Date of Birth	Relationship

The term "dependent" is limited to the employee's spouse, unmarried children to age 26, principally dependent upon the employee for maintenance and support, residing in the United States or Canada. Coverage for a handicapped child may be continued past the age limits. Proof that your child is fully handicapped must be submitted to Aetna no later than 31 days after the date your child reaches the maximum age under the plan.

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

Employee Signature

Employer Representative (Certified) Date