



**Employee Information**

LAST NAME	FIRST	INITIAL	EMPLOYEE ID NO.
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**Child Custody Information**

If you or your spouse are divorced or legally separated, please indicate who has custody of your child(ren).	<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Other
Has the parent without custody been mandated by court decree to provide coverage for the dependent child(ren)?	<input type="checkbox"/> Yes If yes, complete the "Family Members Covered Under Other Coverage" section below. <input type="checkbox"/> No

**Family Members Covered Under Other Coverage**

To be completed only if you, or a dependent you are enrolling through the Trust, has other insurance.

NAME OF FAMILY MEMBER WITH OTHER COVERAGE	DATE OF BIRTH	NAME OF OTHER INSURANCE PLAN
NAME OF EMPLOYEE	GROUP ID NUMBER	EFFECTIVE DATE OF COVERAGE

CLAIMS ADDRESS

**Optional Term Life and Voluntary AD&D Insurance** GROUP NUMBER 750971

<b>LIFE INSURANCE</b> <input type="checkbox"/> OPTIONAL (Additional) Term Life	REQUESTED AMOUNT \$	(Evidence of Insurability is required for amounts above \$100,000.)
<b>DEPENDENTS TERM LIFE INSURANCE</b> <input type="checkbox"/> SPOUSE (Additional) Term Life	REQUESTED AMOUNT \$	(Evidence of Insurability is required for amounts above \$30,000.)
<b>DEPENDENTS TERM LIFE INSURANCE</b> <input type="checkbox"/> CHILD(REN) Term Life	REQUESTED AMOUNT \$	(You may choose an increment of \$2,000 to a maximum of \$10,000.)

**VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE**  
YOU MAY CHOOSE ONE OF THE FOLLOWING OPTIONS:  You only (Up to \$300,000)  You and your dependents \$

**Beneficiary Designation for Basic Life/Optional Term Life and AD&D Insurance**

Unless specified otherwise on a separate sheet of paper, this designation will also apply to Voluntary Accidental Death and Dismemberment (AD&D) insurance. Designations are not valid unless signed, dated and delivered to the Employer in your lifetime.

I elect:  The Standard Order of Survivorship as stated in your group certificate — If you have a Domestic Partner, an Affidavit must be on file for distribution.  
 To designate the following as beneficiary — Attach additional sheets if necessary.  
Total of primary percentages must = 100%      Total of contingent percentages must = 100%

NAME	ADDRESS	RELATIONSHIP	PRIMARY	CONTINGENT	WHOLE %
			<input type="checkbox"/>	OR <input type="checkbox"/>	%
			<input type="checkbox"/>	OR <input type="checkbox"/>	%
			<input type="checkbox"/>	OR <input type="checkbox"/>	%
			<input type="checkbox"/>	OR <input type="checkbox"/>	%

**Signature**

My signature below indicates that I have read and understand this enrollment form and descriptive materials provided. This enrollment form is binding on me and cannot be revoked or modified except as explained in the descriptive materials provided. I authorize my insurance carriers to obtain, examine, or release any medical or dental records or other information needed to coordinate benefits or process claims for me and my family members. I also authorize any provider having knowledge of my medical history or my dependents to release to my insurance carriers any medical information it requests. I authorize my insurance carriers to share such medical information with me or my dependents' health care providers. I declare that the dependents listed on this form are my eligible dependents. I also declare that the information furnished on this form is correct and complete to the best of my knowledge.

SIGNATURE VERIFYING I'VE READ AND UNDERSTAND MATERIAL \_\_\_\_\_ DATE \_\_\_\_\_

**Declaration to Decline Coverage**

I hereby decline coverage for Medical, Dental, Vision, Life Insurance, Accidental Death and Dismemberment, or Long-Term Disability coverage provided through School District No. 1 Health and Welfare Trust. I understand that I may not enroll for coverage until the next open enrollment period, unless I have a qualified change in status event. I understand that if I decide to enroll at a later date, I may be required to provide satisfactory Evidence of Insurability and the insurance carrier will have the right to refuse my request for insurance.

SIGNATURE TO DECLINE COVERAGE \_\_\_\_\_ DATE \_\_\_\_\_