To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment

To Be Completed By Applicant

Apply for Coverage Beneficiary Change *Complete Beneficiary Section below.* Name Change
Add or Delete Dependent Date of add/delete _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	Male Female

Your Address	City	State	ZIP

Former Name (Last, First, Middle) *Complete only if name change*	Phone Number

Employer Name	Job Title/Occupation

Hours Worked Per Week	Earnings $_____ Per: Hour Week Month Year

Have you or your spouse used tobacco in any form in the last 12 months? Member: Yes No Spouse: Yes No

Coverage ***Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.***

1. Life and Accidental Death and Dismemberment (AD&D) Insurance

Life (Employer Paid) Voluntary Life Your requested amount $ _____
Life with AD&D (Employer Paid) Voluntary Life with AD&D Your requested amount $ _____
Additional/Optional Life Additional/Optional Life with AD&D Your requested amount $ _____

2. Dependents Life and AD&D Insurance

Spouse Life Requested amount $_____ Spouse Life with AD&D Requested amount $_____
Spouse Name _____ Date of Birth _____
Child(ren) Life Requested amount $_____ Child(ren) Life with AD&D Requested amount $_____

3. Voluntary Accidental Death and Dismemberment (AD&D) Insurance

You only $_____ Your Spouse $_____ or _____ % Your Child(ren) $_____ or_____%

4. Supplemental Life Insurance Your requested amount $_____ Spouse requested amount $_____

5. Short Term Disability Employer Paid Voluntary STD Buy-up

6. Long Term Disability Employer Paid Voluntary LTD Buy-up

7. Dental (see below) Employer Paid Voluntary Dental Low Dental Plan High Dental Plan

8. Vision (see below) Employer Paid Voluntary Balanced Care Vision Plan 1 Plan 2 Plan 3

Dental and Vision ***If you are enrolling in Dental and/or Vision, please provide the following information.***

Coverage requested for Dental You, your Spouse and Children You and your Spouse You only You and your Children (no Spouse)
Coverage requested for Vision You, your Spouse and Children You and your Spouse You only You and your Children (no Spouse)
Are you covered for dental insurance under another plan? Yes No Are one or more Dependents? Yes No

List Dependents to enroll or delete. (Last name if different, First, Middle Initial)	Sex M	Sex F	Date of Birth	*List Dependents to enroll or delete.* (Attach sheet for additional Dependents if needed.)	Sex M	Sex F	Date of Birth
Spouse				Child 2			
Child 1				Child 3			

Dental and Vision Insurance Waiver: Contributory Dental and/or Vision Insurance

The Insurance coverage available to me and my Dependents has been explained to me and I do not want to enroll at this time. I understand that if I elect to enroll in the future, the Insurance coverage may be subject to a Late Enrollment Penalty.

I decline Dental and/or Vision Insurance for myself. I decline Dental and/or Vision Insurance for one or more Dependents.

Beneficiary ***This designation applies to coverage available through your Employer, if any, under Coverage Section 1 or 3 above. Unless specified otherwise on a separate sheet of paper, this designation will also apply to coverage available through your Employer, if any, under Coverage Section 4 above. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.***

Primary – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Contingent – Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Signature

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. I represent that the statements contained herein are true and complete, to the best of my knowledge and belief. I acknowledge that I have read the Fraud Notice which pertains to my state of residency on the back of this form.

Member/Employee Signature Required _____ Date (Mo/Day/Yr)_____

Return completed form to your Human Resources Department.

Beneficiary Information

- Your designation revokes all prior designations.

- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).

- If you name two or more Beneficiaries in a class:

    1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.

    2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.

    3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____ ."

- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.

- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

Fraud Notices

FOR RESIDENTS OF AR, DC, KY, LA, ME, NM, OH, TN: Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

FOR RESIDENTS OF CO: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to the policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

FOR RESIDENTS OF NY: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

FOR RESIDENT OF PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.