

New Enrollment    Change    Open Enrollment    Retiree

**Employer/Employee Section**

Enrollment forms must be submitted directly to Dearborn National unless the group is self-administered. If the group is self-administered, submit enrollment forms to Dearborn National only if evidence of insurability is required.

EMPLOYER Ector County		GROUP NO. / ACCOUNT NUMBER VF023316		LOCATION	
EMPLOYEE NAME - LAST	FIRST	MIDDLE INITIAL	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH	DATE OF HIRE (FULL TIME)
SOCIAL SECURITY NO.	EARNINGS Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual <input type="checkbox"/>		JOB TITLE		CLASS
HOME ADDRESS			CITY	STATE	ZIP
HOME PHONE	WORK PHONE		CELL PHONE		

**BENEFIT SELECTION - Life**

**COVERAGE SELECTION:** Your non-medical group insurance program may not include all the benefits listed below. **Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.**

**Basic Coverage (Check all that apply)**

Term Life / AD&D

**Supplemental Coverage (check all that apply)**

	(A)Add, (C)Change (D)Delete	Total Amount of Coverage Desired	If (C)hange, list Prior Coverage
<input type="checkbox"/> Term Life Employee			
<input type="checkbox"/> Term Life Spouse			
<input type="checkbox"/> Term Life Child(ren)			

SPOUSE NAME (if Applicant) - LAST	FIRST	M.I.	SEX <input type="checkbox"/> M <input type="checkbox"/> F	SPOUSE DATE OF BIRTH	SPOUSE SOCIAL SECURITY #
-----------------------------------	-------	------	--	----------------------	--------------------------

**BENEFICIARY DESIGNATION:** (For Employee Only: Must Be Completed if you have applied for Life or AD&D insurance.) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

First Name	Last Name	Social Security No.	Date of Birth	Relationship	Percentage %
Primary					%
Primary					%
Contingent					%
Contingent					%

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy (ies) issued to the employer listed above. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I do not remain actively at work that my coverage may lapse or terminate. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.

FOR DEARBORN NATIONAL  
USE ONLY

EMPLOYEE SIGNATURE \_\_\_\_\_

DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**Waiver of Coverage:**

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the company.

EMPLOYEE SIGNATURE \_\_\_\_\_

DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_