Life Insurance Enrollment

BC Life & Health Insurance Company

Instructions (Please send completed form to BC Life & Health)

For selecting benefits, please complete and sign Sections 1-3 and 5.
Be sure to complete coverages selected and indicate benefit amount.
If declining coverage, complete Sections 1, 2 & 4.

☐ New Enrollment ☐ Re-hire ☐ Re-enrollment

GROUP NO.

1. Personal Information

LAST NAME (Print)	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	SEX 1 ☐ M 2 ☐ F	DATE OF BIRTH MO / DAY / YR

STREET ADDRESS	CITY	STATE	ZIP

TELEPHONE NO. Area Code ( )	EMPLOYER	DATE HIRED / REHIRE DATE MO / DAY / YR	ARE YOU RETIRED? ☐ YES ☐ NO	DATE OF RETIREMENT MO / DAY / YR

JOB TITLE	DEPT. NO.	CLASS	ANNUAL SALARY	MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED

2. Coverage Election

Complete the boxes by checking (√) them to indicate your Coverage Elections.

- *All the coverages listed may not be offered under your plan.*
- *To elect dependent coverage, the corresponding employee coverage must be elected.*

	Elected	Benefit Amount	Refused
Life (AD&D).....	☐	_____	☐
Dependent Life	☐	_____	☐
Supplemental Life	☐	_____	☐
Supplemental AD&D	☐	_____	☐
Other _____	☐	_____	☐

3. Beneficiary Employee Life Designation *Note Dependent Life payments are always paid to the employee.

Primary Beneficiary – First to Receive Payment (required) *– If more than 1 beneficiary is named, enter a % for each.*

☐ Named Individuals (Enter the name, address, date of birth, social security number and relationship to the insured for each name listed.)

NAME	ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP	%
NAME	ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP	%

☐ Estate of Insured
☐ Revocable or Irrevocable Trust (Enter the name of the Trustee, name of Trust and complete date of Trust.)
☐ Trustee Under Insured's Will (If choosing this option DO NOT enter additional names in the Primary Beneficiary field.)

Secondary Beneficiary – Second to Receive Payment (optional) *– If more than 1 beneficiary is named, enter a % for each.*

☐ Named Individuals (Enter the name, address, date of birth, social security number and relationship to the insured for each name listed.)

NAME	ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP	%
NAME	ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP	%

☐ Estate of Insured
☐ Revocable or Irrevocable Trust (Enter the name of the Trustee, name of Trust and complete date of Trust.)
☐ Trustee Under Insured's Will (If choosing this option DO NOT enter additional names in the Secondary Beneficiary field.)

4. Declination of Coverage *(Signature Required)*

I hereby decline insurance for the group life coverages which I have refused. This refusal of coverage applies to myself as well as any of my eligible dependents (if applicable). I understand that if I wish to apply for this coverage at a future date, I will then have to comply with the rules governing late applicants.

SIGNATURE	DATE

5. Employee Authorization *(Signature Required)*

I hereby apply for the insurance for which I am now or may become eligible under the group policy or policies issued to the policyholder by BC Life & Health Insurance Company. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such insurance, which authorization may be revoked by me at any time by prior written notice to the policyholder. I understand that if my employment is terminated, upon re-employment, insurance will not become effective until I again apply for insurance in accordance with the terms of the group policy. To the best of my knowledge and belief, the information I have provided on this form is complete and correct.

EMPLOYEE'S SIGNATURE	DATE