

LIFE INSURANCE ENROLLMENT

TO BE COMPLETED BY THE EMPLOYER			
Policy # _____			
Employer/Policyholder Name _____			
Street Address _____	City _____	State _____	Zip Code _____
Employee Occupation/Job Title _____	Employee Date of Employment _____		
Effective Date of Coverage _____	<input type="checkbox"/> Full Time Employee		<input type="checkbox"/> Part Time Employee
\$ _____ / <input type="checkbox"/> HR <input type="checkbox"/> WK <input type="checkbox"/> MO <input type="checkbox"/> YR	Class Number (if applicable) _____		
Basic Earnings			

I. EMPLOYEE INFORMATION

Name _____ Sex M F

Street Address _____ City _____ State _____ Zip Code _____

Home Telephone Number _____ Date of Birth _____ Marital Status _____

II. BENEFITS (Please check if you wish to enroll and include the benefit amount)

	Yes	No		Election Amount ↓
Employee Life	_____	_____	_____ x BAE* or \$ _____	_____
Employee AD&D	_____	_____	_____ x BAE* or \$ _____	_____
Employee Supplemental Life	_____	_____	_____ x BAE* or \$ _____	_____
Employee Supplemental AD&D	_____	_____	_____ x BAE* or \$ _____	_____
Dependent Life				
Spouse	_____	_____	_____ x BAE* or \$ _____	_____
Child	_____	_____	_____ x BAE* or \$ _____	_____
Spouse & Child	_____	_____	_____ x BAE* or \$ _____	_____
Dependent AD&D				
Spouse	_____	_____	_____ x BAE* or \$ _____	_____
Dependent Supplemental Life	_____	_____	_____ x BAE* or \$ _____	_____
Spouse	_____	_____	_____ x BAE* or \$ _____	_____
Child	_____	_____	_____ x BAE* or \$ _____	_____
Spouse & Child	_____	_____	_____ x BAE* or \$ _____	_____
Dependent Supplemental AD&D	_____	_____	_____ x BAE* or \$ _____	_____
Spouse	_____	_____	_____ x BAE* or \$ _____	_____
Other	_____	_____	_____ x BAE* or \$ _____	_____
Other _____	_____	_____	_____ x BAE* or \$ _____	_____
Other _____	_____	_____	_____ x BAE* or \$ _____	_____

*BAE: Basic Annual Earnings as defined in your contract

III. BENEFICIARY DESIGNATION

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

	NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP	% OF BENEFIT
<input type="checkbox"/> Primary					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					

IV. SELECTION/WAIVER OF GROUP INSURANCE

I, the undersigned, an employee of the above-named policyholder, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance (**Not applicable if the [Employer] pays 100% of the required contribution**).

I hereby waive my right at this time to elect the insurance coverages which I did not select above. I understand that if I do not enroll within 31 days, when first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death.

All information submitted by me on this form to the best of my knowledge and belief is true and complete.

Employee Signature

Date Signed

Please read the following notice that we are required by law to give to you.

Florida Law States:

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Group Benefits are insured by Symetra Life Insurance Company.

Symetra® is a registered service mark of Symetra Life Insurance Company.