Life and AD&D Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. <u>All</u> new coverage or <u>any</u> increases in Life coverage will require evidence of insurability (proof of good health) if plan participation requirements are not met. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

Name of Employer/Plan Sponsor				Group/Plan Number			Account Number/Location	
City of LaPorte			65636-4			1		
Class/Occupation	Date of Hire	Annual Sa	lary		. ,		me □ Retired	
This shows is due to /shoot all the	channel in Channel in C) }		Status:	Ц	Active Part-T		
This change is due to: (check all that apply)Change in Coverage AmLate Entrant*			nountOt	ther:		Change:	ate of Coverage or	
<u> </u>			71					
*A late entrant is an individual who is first	t enrolling for supplemental (or dependent	coverage after	r the first avail	able opp	oortunity.		
Employee Information	+						_	
Employee Name (last, first, middle initial)		☐ Female Date of Birth / /		Social	Social Security #		Employee I.D. #	
Employee Address (street address, city, state, zip code)				Teleph	none			
				Work ()				
				Home	()	<u> </u>		
Employee Life Insurance								
Basic Life ⊠ Er	nployee Only—Elect Cover	age (Note: Ba	asic Life insuran	nce is employer	provided	d.)		
Employee Appidental Death 8	Dismomborment Inc	uranaa						
Employee Accidental Death & Basic AD&D	nployee Only—Elect Cover		asic AD&D insul	rance is emplo	ver provid	ded.)		
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Beneficiary Information Designation				1			T = 0.07	
Name of Beneficiary (last name, first, middle initial)			☐ Primary Relationship to Er			to Employee	Benefit %	
Address			Date of Bi	rth Soc	ial Secu	rity Number	Phone Number	
						-		
Name of Beneficiary (last name, first, i	middle initial)	☐ Primary	☐ Conting	ent Rela	tionship	to Employee	Benefit %	
Address			Date of Bi	rth Soc	ial Secu	rity Number	Phone Number	
Name of Danielians (last name first	المالية	Duine and		and Dalat	li a sa a la isa	to Employee	Danasit 0/	
Name of Beneficiary (last name, first, i	midale inilial)	☐ Primary	☐ Conting	ent Reia	lionsnip	to Employee	Benefit %	
Addross			Date of Bi	rth Coo	ial Cagu	rity Number	Phone Number	
Address			Date of Bi	1111 300	iai Secu	nty Number	Phone Number	
L								
READ THIS INFORMATION CA	REFULLY AND THE	N SIGN AN	ID DATE B	ELOW				
I authorize my employer to deduct								
 To the best of my knowledge and be 								
I understand my coverage begins of the state of the					ely at w	ork.		
I also understand that evidence of Francisco la Signature	insurability may be required	d for coverag	e to become e	ettective.	D-4-	Ciana a -l		
Employee's Signature					Date	Signed		
						/	/	