

New Enrollment    Change    Open Enrollment    COBRA    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 Regional Office of Education		GROUP NO. / ACCOUNT NUMBER F173583		LOCATION	
EMPLOYEE NAME - LAST	FIRST	MIDDLE INITIAL	SEX M <input type="checkbox"/> F <input type="checkbox"/>	DATE OF BIRTH	DATE OF HIRE (FULL TIME)
SOCIAL SECURITY NO.		EARNINGS \$ 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**

Term Life / AD&D

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

Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.

	(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)			
<input type="checkbox"/> Voluntary AD&D <input type="checkbox"/> Employee <input type="checkbox"/> Family			

Spouse Name - Last (If Applicant)	First	M.I.	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Spouse Date of Birth	Spouse Social Security #
--------------------------------------	-------	------	--	----------------------	--------------------------

Has the employee (if applying) used <b>any</b> tobacco products in the last 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the spouse (if applying) used <b>any</b> tobacco products in the last 2 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**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					%

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 \_\_\_\_/\_\_\_\_/\_\_\_\_