

**LIFE INSURANCE
ENROLLMENT FORM**

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	FULL OR PART TIME EMPLOYEE		
\$ _____ / HR WK MO 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 BENEFIT AMOUNT

Employee Life:	YES	NO	X BAE*	OR	\$
Employee AD&D:	YES	NO	X BAE*	OR	\$
Employee Supplemental Life:	YES	NO	X BAE*	OR	\$
Employee Supplemental AD&D:	YES	NO	X BAE*	OR	\$
Dependent Life:					
Spouse:	YES	NO	X BAE*	OR	\$
Child:	YES	NO	X BAE*	OR	\$
Spouse & Child:	YES	NO	X BAE*	OR	\$
Dependent AD&D:					
Spouse:	YES	NO	X BAE*	OR	\$
Dependent Supplemental Life:					
Spouse:	YES	NO	X BAE*	OR	\$
Child:	YES	NO	X BAE*	OR	\$
Spouse & Child:	YES	NO	X BAE*	OR	\$
Dependent Supplemental AD&D:					
Spouse:	YES	NO	X BAE*	OR	\$
Other:	YES	NO	X BAE*	OR	\$
Other:	YES	NO	X BAE*	OR	\$
Other:	YES	NO	X BAE*	OR	\$

* BAE: Basic Annual Earnings as defined in your contract

III. BENEFICIARY DESIGNATION

Definitions:

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	D.O.B	RELATIONSHIP	PRIMARY	CONTINGENT	% OF BENEFIT

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