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SYMETRA SM
FINANCIAL

Mailing Address:
Symetra Life Insurance Company
Group Division
PO Box 34690
Seattle, WA 98124-1690

DISABILITY INCOME 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**
BASIC EARNINGS | **CLASS NUMBER (IF APPLICABLE)**

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

Short-Term Disability Income Insurance:	☐ YES	☐ NO	%	OR	$
Long-Term Disability Income Insurance:	☐ YES	☐ NO	%	OR	$
Voluntary Short-Term Disability Income Insurance:	☐ YES	☐ NO	%	OR	$
Voluntary Long-Term Disability Income Insurance:	☐ YES	☐ NO	%	OR	$
Other:	☐ YES	☐ NO	%	OR	$
Other:	☐ YES	☐ NO	%	OR	$
Other:	☐ YES	☐ NO	%	OR	$

III. 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.

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

EMPLOYEE SIGNATURE _____ **DATE SIGNED** _____