Group Life Insurance Enrollment Form

Instructions: Please complete all sections of this form. This template is designed to be printed and filled out or typed directly before printing.

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1. Employer and Group Information

Employer / Group Name: _____

Group Policy Number: _____ Division / Location: _____

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2. Employee Personal Information

Full Legal Name (Last, First, Middle): _____

Social Security Number: _____ Date of Birth (MM/DD/YYYY): _____ Gender (Male/Female): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Email Address: _____

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3. Coverage Selection

Please enter "ENROLL" or "WAIVE" for each coverage option, and specify requested amounts if applicable.

Basic Employee Term Life & AD&D (Employer Provided): ENROLL or WAIVE

Supplemental Employee Life Insurance (Requested Amount $): _____

Spouse Supplemental Life Insurance (Requested Amount $): _____

Dependent Child Supplemental Life Insurance (Requested Amount $): _____

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4. Beneficiary Designation

Specify who should receive the insurance benefit in the event of your death. Percentages must total 100%.

Primary Beneficiary 1

Full Name: _____ Relationship: _____ Share Percentage (%): _____

Address: _____

Primary Beneficiary 2

Full Name: _____ Relationship: _____ Share Percentage (%): _____

Address: _____

Contingent Beneficiary (Receives benefit only if all primary beneficiaries are deceased)

Full Name: _____ Relationship: _____ Share Percentage (%): _____

Address:

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5. Authorization and Signature

I represent that all statements made on this enrollment template are true and complete to the best of my knowledge. If any premiums are required, I authorize my employer to deduct them from my salary.

Employee Signature (Sign after printing): Date (MM/DD/YYYY):