Dearborn National

# ENROLLMENT and CHANGE FORM

Underwritten by Dearborn National® Life Insurance Company

**Administrative Offices**: Downers Grove, Illinois | Dallas, Texas

☐ 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 | GROUP NO./ACCOUNT NUMBER | LOCATION |
|---|---|---|
| | | |

| EMPLOYEE NAME – LAST | FIRST | MIDDLE INITIAL | GENDER ☐ M ☐ F | DATE OF BIRTH | DATE OF HIRE (FULL TIME) | DATE OF REHIRE |
|---|---|---|---|---|---|---|
| | | | | | | |

| SOCIAL SECURITY NO. | EARNINGS $ ☐ Weekly ☐ Monthly ☐ Annual | JOB TITLE | CLASS |
|---|---|---|---|
| | | | |

| HOME ADDRESS | CITY | STATE | ZIP |
|---|---|---|---|
| | | TX | |

| 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 (Employer Paid)** ☒ Term Life/AD&D

**Supplemental Coverage (Employee Paid)** - Spouse includes Domestic Partner as defined in the Certificate.

| SUPPLEMENTAL Life/AD&D – Employee | SUPPLEMENTAL Life/AD&D – Spouse | Dependent Child(ren): (Cost per Family unit) | |
|---|---|---|---|
| Please Select One: | Please Select One: | Please Select One: | |
| Benefit | Benefit | Benefit | Monthly Premium* |
| ☐ $20,000 | ☐ $ 10,000 | ☐ $10,000 | $1.00 |
| ☐ $40,000 | ☐ $ 20,000 | ☐ NONE | |
| ☐ $60,000 | ☐ $ 30,000 | | |
| ☐ $80,000 | ☐ $ 40,000 | | |
| ☐ $100,000 | ☐ ***$ 50,000*** ** | | |
| ☐ ***$150,000*** ** | ☐ Other: $ | | |
| ☐ Other: $ | ☐ NONE | | |
| ☐ NONE | | | |

* Premiums shown are based on 12 payroll deductions per year. Premiums are estimates and could vary due to amounts selected and approved as well as rounding. ** ***GUARANTEE ISSUE AMOUNT***

***NOTE:*** Employee must elect Supplemental life coverage in order to elect spouse and/or dependent coverage.

| SPOUSE NAME-LAST | FIRST | M.I. | SEX M☐ F☐ | SPOUSE DATE OF BIRTH | SPOUSE SOCIAL SECURITY # |
|---|---|---|---|---|---|
| | | | | | |

**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 | DATE OF BIRTH | RELATIONSHIP | SOCIAL SECURITY # | BENEFIT % |
|---|---|---|---|---|---|
| Primary | | | | | % |
| Primary | | | | | % |
| Contingent | | | | | % |

I HEREBY REQUEST TO BE INSURED AND AUTHORIZE DEDUCTIONS, IF ANY, FROM MY COMPENSATION FOR MY SHARE OF THE COST OF THE BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE GROUP POLICY (IES) ISSUED TO THE EMPLOYER LISTED ABOVE. I UNDERSTAND THAT IF I AM NOT ACTIVELY AT WORK ON THE EFFECTIVE DATE OF MY COVERAGE, MY INSURANCE WILL NOT BEGIN UNTIL THE DAY I RETURN TO WORK. FOR THOSE COVERAGES I HAVE DECLINED, I UNDERSTAND THAT IF I CHOOSE TO ENROLL AT A LATER DATE, MY COST MAY BE HIGHER AND A HEALTH QUESTIONNAIRE MAY BE REQUIRED.

EMPLOYEE SIGNATURE _____ DATE ____/____/____