

## GROUP LIFE INSURANCE ENROLLMENT

### TO BE COMPLETED BY THE POLICYHOLDER

Policy Number _____			
Employer/Policyholder Name _____			
Street Address _____	City _____	State _____	Zip Code _____
Employee Occupation/Job Title _____	Employee Date of Employment _____		
Effective Date of Coverage _____	<input type="checkbox"/> Full Time Employee <input type="checkbox"/> Part Time Employee		
\$ _____ / <input type="checkbox"/> HR <input type="checkbox"/> WK <input type="checkbox"/> MO <input type="checkbox"/> YR	Class Number (if applicable) _____		
Basic Earnings _____			

### I. EMPLOYEE/ENROLLEE INFORMATION

Name _____	Sex	<input type="checkbox"/> M	<input type="checkbox"/> F
Street Address _____	City _____	State _____	Zip Code _____
Home Telephone Number _____	Date of Birth _____	Marital Status _____	

### II. BENEFITS (Please check if you wish to enroll)

*Please contact your HR representative with any questions*

	Yes	No	Indicate the benefit amount
Employee Life			x BAE <sup>1</sup> or \$
Employee AD&D			x BAE <sup>1</sup> or \$
Employee Supplemental Life			x BAE <sup>1</sup> or \$
Employee Supplemental AD&D			x BAE <sup>1</sup> or \$
<b>Dependents who are Confined will be subject to a Deferred Effective Date – see your Certificate for details.</b>			
Dependent Life	<sup>2</sup> Please provide the <b>name</b> and <b>birth date</b> for <b>each dependent</b> below.		
Spouse <sup>2</sup>			x BAE <sup>1</sup> or \$
Child <sup>2</sup>			x BAE <sup>1</sup> or \$
Spouse & Child <sup>2</sup>			x BAE <sup>1</sup> or \$
Dependent AD&D			
Spouse <sup>2</sup>			x BAE <sup>1</sup> or \$
Dependent Supplemental Life			
Spouse <sup>2</sup>			x BAE <sup>1</sup> or \$
Child <sup>2</sup>			x BAE <sup>1</sup> or \$
Spouse & Child <sup>2</sup>			x BAE <sup>1</sup> or \$
Dependent Supplemental AD&D			
Spouse <sup>2</sup>			x BAE <sup>1</sup> or \$
Other			% or \$

<sup>1</sup>BAE: Basic Annual Earnings as defined in your contract.

<sup>2</sup> List Dependents' names and birthdates (use another page if needed).

Name	Relationship	Date of Birth	Name	Relationship	Date of Birth

**III. BENEFICIARY DESIGNATION**

**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	DATE OF BIRTH	RELATIONSHIP	% OF BENEFIT
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					

**IV. SELECTION/WAIVER OF GROUP INSURANCE** (Only check one box below, and sign.)

- I, the undersigned, 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 Policyholder pays 100% of the required contribution**).
- I, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 31 days of the date I am 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.

\_\_\_\_\_  
Enrollee/Employee Signature

\_\_\_\_\_  
Date Signed

Group Benefits are insured by Symetra Life Insurance Company.