INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Offered by Life Insurance Company of North America

Employer: Snow College

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ **Social Security #** _____ **Birthdate** _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Gender: ____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE

❑ I am currently married and my date of marriage is: _____

My Spouse's Information

Name _____ **Social Security #** _____

Birthdate _____ Gender _____

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employee-Paid (Voluntary) Term Life Insurance Policy # FLX 969777

Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Units of $10,000 up to the lesser of 5 times your salary, or $500,000. Guaranteed Coverage: $200,000	❑ $10,000 ❑ $200,000* ❑ $500,000** ❑ Other _____ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
Spouse	Units of $5,000 up to $250,000. Guaranteed Coverage: $30,000	❑ $5,000 ❑ $30,000* ❑ $250,000** ❑ Other _____ *Amount must be a multiple of $5,000. The amount cannot exceed 100% of the employee's coverage.* ❑ Decline Coverage
Child	Units of $10,000 up to $10,000.	❑ $10,000 ❑ $10,000** ❑ Other _____ *Amount must be a multiple of $10,000.* ❑ Decline Coverage

Employee-Paid (Voluntary) Short-term Disability Insurance Policy # VDT 963212

Applicant	Review your available plan below before accepting or declining coverage.	
Employee	Benefit Percentage: 60%	❑ Accept Coverage
	Maximum Weekly Benefit Amount: $1,500	❑ Decline Coverage

***This is the maximum amount that you can choose under this plan.*
All coverage elected during this enrollment period will take effect on the latest of 07/01/2023, the date your election form is received by your employer, or if applicable the day your Evidence of Insurability Form is approved by the Insurance Company.

Please turn to other side to complete enrollment process.
Be sure to make a copy for your records.

SIGN HERE TO ACCEPT YOUR DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to New York Life Group Benefit Solutions' approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by UT: Life Insurance Company of North America.

Pre-Existing Condition Limitation: I understand that I will not receive benefits for a pre-existing condition (any injury or sickness for which medical advice, care or treatment was recommended or received during the months just prior to the coverage effective date) unless the disability begins more than 3 months after the effective date of coverage.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 6 months for the Disability coverage.

Please Sign Here ☛ Signature _____ Date _____

BENEFICIARY SECTION

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and child(ren). If you need additional space to indicate your beneficiary designations, attach a separate piece of paper using the below format including the appropriate policy number, the date, and your signature.

Voluntary Life Insurance			Policy No. FLX 969777	
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

Community Property Laws—If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary payment of benefits may be delayed or disputed unless your spouse provides their signature in the space provided below.

Spouse Signature _____ Date ____/____/____

Employee Signature _____ Date ____/____/____

Created on 09/2022.