

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT	Your Name (Last, First, Middle)		Group Name City of Springfield		Group Number(s) 612599	
	Your Address		City		State	ZIP
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation	

LIFE	Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.					
	Life Insurance					
	<input checked="" type="checkbox"/> Life with AD&D Employer Paid					
	Additional/Optional Life <input type="checkbox"/> Additional/Optional Life Your requested amount \$ _____					
Dependents Life Insurance						
<input type="checkbox"/> Spouse requested amount \$ _____ Spouse Name _____ Date of Birth _____						
<input type="checkbox"/> Children requested amount \$ _____						
Accidental Death and Dismemberment (AD&D) Insurance						
<input type="checkbox"/> Employee Only <input type="checkbox"/> Employee and Family Your requested amount \$ _____						

DISABILITY	Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.					
	Long Term Disability					
<input checked="" type="checkbox"/> Employer Paid LTD						

BENEFICIARY	This designation applies to Life Insurance available through your Employer, if any. Unless specified otherwise on a separate sheet of paper, this designation will also apply to Accidental Death and Dismemberment (AD&D) Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.					
	Primary - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
	Contingent - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit

CHANGE	Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.					
	<input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent		<input type="checkbox"/> Name Change		<input type="checkbox"/> Beneficiary Change	
Date of add/delete _____		Former name _____		<input type="checkbox"/> Other _____		

SIGNATURE	I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.					
	Member/Employee Signature Required				Date (Mo/Day/Yr)	

Human Resources Department - Complete this section. Retain form for your records.

Dvsn ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr
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