

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

APPLICANT	Your Name (Last, First, Middle)		Group Name <u>City of Cabot</u>		Group Number(s)		
	Your Address		City		State	Zip	
	Your Soc. Sec. No.	Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation	
COVERAGE SECTION	Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.						
	1. Life Insurance <input type="checkbox"/> Life <input type="checkbox"/> Life with AD&D Employer paid amount \$ <u>20,000</u> <input type="checkbox"/> Additional/Optional Life <input type="checkbox"/> Additional/Optional Life with AD&D Your requested amount \$ _____						
	2. Voluntary Life Insurance <input type="checkbox"/> Voluntary Life <input type="checkbox"/> Voluntary Life with AD&D Your requested amount \$ _____						
	3. Dependents Life Insurance <input type="checkbox"/> Spouse requested amount \$ <u>5000</u> Spouse Name _____ Date of Birth _____ <input type="checkbox"/> Children requested amount \$ <u>2000</u>						
	4. Accidental Death and Dismemberment (AD&D) Insurance <input type="checkbox"/> AD&D Employer paid amount \$ _____ <input type="checkbox"/> Voluntary AD&D Your requested amount \$ _____						
	5. Supplemental Life Insurance Your requested amount \$ _____ Spouse requested amount \$ _____						
	6. Short Term Disability <input type="checkbox"/> Employer Paid <input type="checkbox"/> Enhanced (Buy-up) <input type="checkbox"/> Voluntary STD 7. Long Term Disability <input type="checkbox"/> Employer Paid <input type="checkbox"/> Enhanced (Buy-up) <input type="checkbox"/> Voluntary LTD 8. Dental (See below) <input type="checkbox"/> Employer Paid <input type="checkbox"/> High Plan <input type="checkbox"/> Voluntary Dental						
	DENTAL	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced Coverage requested for <input type="checkbox"/> You, your spouse and children <input type="checkbox"/> You and your spouse <input type="checkbox"/> You only <input type="checkbox"/> You and your children (no spouse) Are you covered for dental insurance under another plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Are one or more dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No					
List dependents to enroll or delete. (Last name if different, First, Middle Initial)		Sex M F	Date of Birth	List dependents to enroll or delete. (Attach sheet for additional dependents if needed.)	Sex M F	Date of Birth	
Spouse				Child 2			
Child 1				Child 3			
Dental Insurance Waiver; Contributory Dental Insurance The Dental Insurance coverage available to me and my Dependents has been explained to me and I do not want to enroll at this time. I understand that if I elect to enroll in the future, the Dental Insurance coverage may be subject to a Late Enrollment Penalty. <input checked="" type="checkbox"/> I decline Dental Insurance for myself <input type="checkbox"/> I decline Dental Insurance for one or more Dependents							
BENEFICIARY	This designation applies to coverage available through your Employer, if any, under Coverage Section 1 or 2 above. Unless specified otherwise on a separate sheet of paper, this designation will also apply to coverage available through your Employer, if any, under Coverage Sections 4 and 5 above. 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		<input type="checkbox"/> Other _____		
Date of add/delete _____		Former name _____					
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.							
Division ID	Billing Category	Date of Hire or Rehire	Hours Worked Per Week	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr		