Employee Name	Social Security #

Benefit Coordination/Other Insurance Carrier Information

1. Does anyone listed have other health insurance? ☐ Yes ☐ No If yes, complete section below ↓	2. Is anyone listed permanently disabled? ☐ Yes ☐ No If yes, complete the following: 2a. Name _____ 2b. Date disability began _____	3. Is anyone listed eligible for Medicare? ☐ Yes ☐ No If yes, complete the following: 3a. Name _____ 3b. Medicare ID# _____

4. If other than English, please indicate enrollee's primary spoken language _____	5. Does the enrollee have a disability affecting their ability to communicate or read? ☐ Yes ☐ No

1a. Name	1b. Insurance Company Name	1c. Policy #	1d. Effective Date	1e. Other Employer Name and Address

*Group Life Insurance (Complete only if your Employer is offering this benefit)

I apply for coverage for: ☐ Self Only ☐ Self and Eligible Dependents	Employee's Benefits – Life: $ AD&D: $ Supp. Life:** $
Spouse – Date of Birth (mm-dd-yy) Amount: $	**Children** – ☐ One child ☐ Two or more Per child amount: $

As a covered employee, you have the right to select and/or change your beneficiary(ies) in accordance with the provisions of your policy.

Life Insurance Primary Beneficiary (full name)***	Phone Number ( )	Relationship***
Contingent Beneficiary (full name)	Phone Number ( )	Relationship

** Evidence of Insurability may be required.
*** Your spouse MUST sign this form if: (a) you are a resident of AZ, CA, ID, LA, NV, NM, TX, WA or WI **and** (b) you designate someone other than your spouse as beneficiary

Spouse Signature	Date

*Group Long Term Disability (LTD) & Group Short Term Disability (STD) Insurance (Complete only if your Employer is offering this benefit)

Job Duties

I understand that a medical examination, at my own expense, may be required if I want to participate at a later date.

Employee Signature X	Date
LTD/STD Insurance Beneficiary (full name)	Relationship

* Life coverage is underwritten by Continental Assurance Company or CNA Group Life Assurance Company. Long Term Disability and Short Term Disability are underwritten by Continental Casualty Company or CNA Group Life Assurance Company. The issuing company is identified on the group policy.

Signature

By signing below, I acknowledge that I have read, understand and agree to the Terms and Conditions on all pages of this form. A reproduction of this authorization shall be as valid as the original.

Signature (Required) X	Date (Required)