



Life Insurance Enrollment

Instructions (Please send completed form to BC Life & Health)

For selecting benefits, please complete and sign Sections 1-3 and 5.
Be sure to complete coverages selected and indicate benefit amount.
If declining coverage, complete Sections 1, 2 & 4.

<input type="checkbox"/> New Enrollment <input type="checkbox"/> Re-hire <input type="checkbox"/> Re-enrollment	GROUP NO. <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> <td style="width:12.5%;"></td> </tr> </table>								

1. Personal Information

LAST NAME (Print)	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER	SEX 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F	DATE OF BIRTH MO DAY YR
STREET ADDRESS			CITY	STATE	ZIP
TELEPHONE NO. Area Code ()	EMPLOYER	DATE HIRED / REHIRE DATE MO DAY YR		ARE YOU RETIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO	DATE OF RETIREMENT MO DAY YR
JOB TITLE	DEPT. NO.	CLASS	ANNUAL SALARY	MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED	

2. Coverage Election

	Elected	Benefit Amount	Refused
Complete the boxes by checking (✓) them to indicate your Coverage Elections.			
Life (AD&D).....	<input type="checkbox"/>	_____	<input type="checkbox"/>
Dependent Life	<input type="checkbox"/>	_____	<input type="checkbox"/>
Supplemental Life	<input type="checkbox"/>	_____	<input type="checkbox"/>
Supplemental AD&D	<input type="checkbox"/>	_____	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	_____	<input type="checkbox"/>

• All the coverages listed may not be offered under your plan.
• To elect dependent coverage, the corresponding employee coverage must be elected.

3. Beneficiary Employee Life Designation *Note Dependent Life payments are always paid to the employee.

Primary Beneficiary – First to Receive Payment (required) – If more than 1 beneficiary is named, enter a % for each.

Named Individuals (Enter the name, address, date of birth, social security number and relationship to the insured for each name listed.)

NAME	ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP	%

- Estate of Insured
- Revocable or Irrevocable Trust (Enter the name of the Trustee, name of Trust and complete date of Trust.)
- Trustee Under Insured's Will (If choosing this option DO NOT enter additional names in the Primary Beneficiary field.)

Secondary Beneficiary – Second to Receive Payment (optional) – If more than 1 beneficiary is named, enter a % for each.

Named Individuals (Enter the name, address, date of birth, social security number and relationship to the insured for each name listed.)

NAME	ADDRESS	DATE OF BIRTH	SOCIAL SECURITY NO.	RELATIONSHIP	%

- Estate of Insured
- Revocable or Irrevocable Trust (Enter the name of the Trustee, name of Trust and complete date of Trust.)
- Trustee Under Insured's Will (If choosing this option DO NOT enter additional names in the Secondary Beneficiary field.)

4. Declination of Coverage (Signature Required)

I hereby decline insurance for the group life coverages which I have refused. This refusal of coverage applies to myself as well as any of my eligible dependents (if applicable). I understand that if I wish to apply for this coverage at a future date, I will then have to comply with the rules governing late applicants.

SIGNATURE	DATE
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5. Employee Authorization (Signature Required)

I hereby apply for the insurance for which I am now or may become eligible under the group policy or policies issued to the policyholder by BC Life & Health Insurance Company. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such insurance, which authorization may be revoked by me at any time by prior written notice to the policyholder. I understand that if my employment is terminated, upon re-employment, insurance will not become effective until I again apply for insurance in accordance with the terms of the group policy. To the best of my knowledge and belief, the information I have provided on this form is complete and correct.

EMPLOYEE'S SIGNATURE	DATE
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