Midwest Regional Office
P.O. Box 2454
Spokane, WA 99210-2454

Custom Group Insurance Enrollment and Record Form

Check reason for completing form:

☐ New Subscriber ☐ Delete Coverage ☐ Add a Family Member
☐ Change Address ☐ Change Name ☐ Terminate a Family Member

Date of Change ______________ Reason for Change ________________

PLANHOLDER NAME (EMPLOYER NAME)			GROUP PLAN NO.	DIVISION
School District OR-1				
PLANHOLDER STREET ADDRESS	CITY	STATE	ZIP	
425 "F" Street	Palmyra	NE	68418	
EMPLOYEE'S NAME (LAST, FIRST, MI)	SOC. SEC. NO.	BIRTHDATE	SEX	
EMPLOYEE'S MAILING ADDRESS	CITY	STATE	ZIP	
OCCUPATION	CLASS	DATE OF FULL TIME EMPLOYMENT	HRS. WK.	
	2			

MARITAL STATUS ☐ Single ☐ Married ☐ Widowed ☐ Legally Separated ☐ Divorced

DEPENDENT CHILDREN ☐ Yes ☐ No

COVERAGE ELECTION

Basic Life (with Accidental Death & Dismemberment) $25,000

EMPLOYEE: **X** This is a company paid benefit which you will receive if you meet eligibility requirements

EMPLOYEE BENEFICIARY DESIGNATION

(Include full proper name and relationship; i.e.: John M. Doe, husband)

	Name:	Relationship:
Primary		
Secondary		

I hereby (1) request coverage for the Group Insurance for which I am or may become eligible; (2) authorize my employer to make the necessary deductions for the contributions, if any, required for insurance, or agree that the contributions be added to my dues; (3) state that I became an employee on the date stated above, and do currently work the number of hours per week stated above; (4) designate the beneficiary named on this form to receive the proceeds, if any, payable in the event of my death; and know my coverage will not take effect unless I am actively at work and life insurance coverage for my dependents will not take effect if a dependent, other than a newborn, is confined to a hospital or other health care facility, or is unable to perform the normal activities of someone of like age and sex.

Any person who, with intent to defraud of knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

I have reviewed the statements on this application and they are true and complete.

SIGNATURE OF EMPLOYEE:	DATE: