Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

Enrollment and Change Form

Administrative Offices: Downers Grove, Illinois I Dallas, Texas

☐ New Enrollment ☐ Change ☐ Open Enrollment ☐ COBRA ☐ Retiree

Employer/Employee Section

Enrollment forms must be submitted directly to Dearborn National unless the group is self-administered. If the group is self-administered, submit enrollment forms to Dearborn National only if evidence of insurability is required.

EMPLOYER	GROUP NO. / ACCOUNT NUMBER	LOCATION
Effingham Community Unit School District #40	F024482	

EMPLOYEE NAME - LAST	FIRST	MIDDLE INITIAL	GENDER ☐ M ☐ F	DATE OF BIRTH	DATE OF HIRE (FULL TIME)

SOCIAL SECURITY NO.	EARNINGS Hourly ☐ Weekly ☐ Monthly ☐ Annual ☐	JOB TITLE	CLASS

HOME ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE

BENEFIT SELECTION - Life

COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. **Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.**

Basic Coverage (check all that apply) Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.

☒ Term Life / AD&D

Supplemental Coverage (check all that apply) Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.		(A)Add, (C)Change (D)Delete	Total Amount of Coverage Desired	If (C)hange, list Prior Coverage
☐ Term Life / AD&D	Employee			
☐ Term Life / AD&D	Spouse			
☐ Term Life / AD&D	Child(ren)			

SPOUSE NAME (if Applicant) - LAST	FIRST	M.I.	SEX ☐ M ☐ F	SPOUSE DATE OF BIRTH	SPOUSE SOCIAL SECURITY #

BENEFICIARY DESIGNATION: (For Employee Only: Must Be Completed if you have applied for Life or AD&D insurance.) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

	First Name Last Name	Social Security No.	Date of Birth	Relationship	Percentage
Primary					%
Primary					%
Contingent					%
Contingent					%

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BENEFIT SELECTION - VISION

ENROLLMENT

Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.

(Choose One)

- ☐ Employee
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Family

POLICY CHANGE

(Check Reason for Change)

- ☐ Married
- ☐ Birth / Adoption
- ☐ Widowed
- ☐ Divorced
- ☐ Address Change

CANCEL COVERAGE

- ☐ Terminate Coverage
  Date / /
- ☐ Leave / Layoff
- ☐ Other
  Date / /

COBRA CONTINUATION PRIVILEGE

Start Date: / /

Projected End Date: / /

Previously covered with group as:

- ☐ 1. Employee (termination, reduction in hours, other)
- ☐ 2. Spouse (divorce from employee, death of employee)
- ☐ 3. Dependent (reached age limit, married, no longer a Full Time Student, other)
- ☐ 4. Spouse & Dependents (divorce from employee, death of employee, other)

For the purposes of this Notice, while prohibited by Federal law, Spouse does not include a same-sex Domestic Partner or Party to a Civil Union. Such benefits may be available under state law if provided by the policyholder.

COVERED SPOUSE AND DEPENDENTS - VISION

Dependent Child(ren) over the age limit, indicate if Full Time Student (FTS) or Handicapped (HDCP).

First Name Last Name	Social Security Number	Date of Birth	Relationship	SEX	Adult Child FTS or HDCP	Name of Accredited School
			SPOUSE	☐ M ☐ F		
				☐ M ☐ F		
				☐ M ☐ F		
				☐ M ☐ F		
				☐ M ☐ F		
				☐ M ☐ F		

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy (ies) issued to the employer listed above. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I do not remain actively at work that my coverage may lapse or terminate. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.

FOR DEARBORN NATIONAL USE ONLY

EMPLOYEE SIGNATURE _____ DATE / /

Waiver of Coverage:

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the company.

EMPLOYEE SIGNATURE _____ DATE / /

EMPLOYER
Effingham Community Unit School District #40

EMPLOYEE NAME - LAST FIRST