



ENROLLMENT FORM FOR GROUP LIFE INSURANCE

Policy Number			Employer Name			
Last Name of Employee		First		M.I.	Social Security Number	
Employee Address, City, State, Zip					Employee Phone Number	
Employment Date MO/DD/YR	Employee's Birth Date MO/DD/YR	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Class	Effective Date MO/DD/YR	Occupation	
Employee Wages <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr \$ _____		Employee's Benefits <input type="checkbox"/> Life: \$ _____		<input type="checkbox"/> AD & D: \$ _____	<input type="checkbox"/> Supp. Life: \$ _____	
Dependent's Life Benefits: <input type="checkbox"/> Yes <input type="checkbox"/> No (If applicable, check eligible dependents below)						
<input type="checkbox"/> Spouse: Date of Birth ___/___/___ Amount: \$ _____			Children: <input type="checkbox"/> One child <input type="checkbox"/> Two or more children Per Child Amount: \$ _____			

As a covered employee, you have the right to select a beneficiary in accordance with the provisions of your policy. You may also have the right to change the beneficiary designated. If more than one beneficiary is designated, payment of the death benefit will be made in equal shares to each of the designated beneficiaries which survive the insured, unless some other allocation is specified by you in writing in accordance with the provisions of the policy. If no designated beneficiary survives the insured, settlement will be made in accordance with the terms of the policy.

Last Name of Primary Beneficiary		First	M.I.	Relationship**
Address & Phone Number			Social Security Number	
Last Name of Contingent Beneficiary		First	M.I.	Relationship**
Address & Phone Number			Social Security Number	

I have read, understand and agree to the provisions printed above and acknowledge that the information I have provided is accurate to the best of my knowledge. I further hereby authorize my employer to make necessary payroll deduction if required.

Insured Signature	Date
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**** Your spouse MUST sign this form if you are a resident of AZ, CA, ID, LA, NV, NM, TX, WA or WI and you designate someone other than your spouse as beneficiary.**

Spouse Signature	Date
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Some common beneficiary designations are outlined below:

- One beneficiary only:* Mary J. Smith, wife (friend, daughter, etc.)
- Two or more beneficiaries, equal amounts:* William S. Smith, father, Alice C. Smith, sister, and Richard B. Smith, brother, equally or to the survivors equally, or to the survivor.
- Two or more beneficiaries, unequal amounts:* 50% to Mary J. Smith, wife, and 25% each to Alice C. Smith, sister, and Richard B. Smith, brother, the share of any deceased beneficiary to be paid in equal shares to the survivors, or to the survivor.
- Primary and contingent beneficiary:* Mary J. Smith, wife, if living, otherwise the children born of the marriage insured to Mary J. Smith equally, or equally to the survivors, or to the survivor.
- Trustee beneficiary:* The Trust Company of Smith, Illinois as trustee under a Trust Instrument dated December 28, 1973.

* The underwriting company will be CNA Group Life Assurance Company. If CNA Group Life Assurance Company is not authorized to issue coverage in connection with the above policy, then coverage will be provided by Continental Assurance Company. PacifiCare is a registered service mark, trade name, and domain name of PacifiCare Health Systems, Inc., and does not underwrite this coverage.