ENROLLMENT • CHANGE FORM

SECTION 1: Group Customer Information *(To be Completed by the Recordkeeper)*

Name of Group Customer/Employer	Group Customer Number	Division	Class	Dept Code
Lawrence County	5966826			

Date of hire *(mm/dd/yyyy)*	Coverage Effective Date *(mm/dd/yyyy)*

SECTION 2: Your Enrollment Information *(To be Completed by the Employee in blue or black ink)*

First Name	Middle Name	Last Name

SSN	Date of birth *(mm/dd/yyyy)*	Gender:	Marital status:
		☐ Male ☐ Female	☐ Single ☐ Married

Address	City	State	ZIP

Job title	Basic annual earnings $		Hours worked per week
		☐ Salaried ☐ Hourly	

☐ New Enrollment ☐ Change in Enrollment

If due to a Qualifying Event, enter date *(mm/dd/yyyy)*

Term Life and Accidental Death & Dismemberment (AD&D) Insurance

☐ Basic Life[1] (Core) Only

☐ Supplemental/Optional Life[1] and AD&D (Buy up)
Enter amount requested $ _____ Monthly Premium $ _____

☐ Supplemental/Optional Dependent Spouse[2] Life[1, 3] and AD&D (Buy up)
Enter amount requested $ _____ Monthly Premium $ _____

☐ Supplemental/Optional Dependent Child Life[3] and AD&D (Buy up)
Enter amount requested $ _____ Monthly Premium $ _____

☐ Waive all supplemental life coverage

Disability Income Insurance

☐ Long Term Disability Benefits Coverage Amount $ _____ Monthly Premium $ _____

☐ Waive Long Term Disability Benefit

Dental Insurance

☐ Dental Option

Select your level of coverage

☐ Employee Only
☐ Employee + Spouse[2]
☐ Employee + Child(ren)
☐ Employee + Spouse[2] + Child(ren)

☐ Waive Dental Coverage

Vision Insurance

☐ Vision Option

Select your level of coverage

☐ Employee Only
☐ Family
☐ Waive Vision

SECTION 3: Dependent Information

If you are applying for coverages for your Spouse and/or Child(ren), please provide the information requested below.

Name of your Spouse *(first, middle, last)*	Date of birth *(mm/dd/yyyy)*	☐ Male ☐ Female
Name(s) of your Child(ren) *(first, middle, last)*	Date of birth *(mm/dd/yyyy)*	☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female
		☐ Male ☐ Female

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your enrollment form.

SECTION □: Beneficiary Designation for Employee Insurance

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the /□□□insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.
I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.

☐ Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name *(first, middle, last)*	SSN	