

**PLEASE COMPLETE AND RETURN THIS FORM TO
WESTERN MUTUAL INSURANCE COMPANY**

Company Name(s): _____ Date: _____

Contact Person: _____ Position: _____

Employee class(es) eligible to participate in the insurance program: _____

Benefit waiting period(s) by employee classification: _____

Hourly work requirement(s) for benefits: _____

Premium contribution percentages:

	<u>Employer</u> <u>Pays</u>	<u>Employee</u> <u>Pays</u>
Percentage/amount of <u>employee</u> premium contributed by:	_____	_____
Percentage/amount of <u>dependant</u> premium contributed by:	_____	_____

Total number of employees of all related companies: _____

Full-time: _____ Part-time: _____ Seasonal: _____

Number of employees eligible to participate in the insurance program: _____

Number of employees participating in the insurance program: _____

Number of eligible employees not participating in the insurance program and their reason(s) for waiving coverage: _____

Company's Current Phone Number: (____) _____ - _____

Company's Current Fax Number: (____) _____ - _____

Current E-Mail Address for Company Contact: _____

Please fax or mail completed form to:

Western Mutual Insurance Company
Attn: Enrollment Department
P.O. Box 572450
Murray, UT 84157-2450
Fax: (801) 263-1247