

WESTERN MUTUAL INSURANCE COMPANY, P.O. BOX 572450, MURRAY, UT 84157-2450  
**HEALTH & VOLUNTARY GROUP LIFE INSURANCE ENROLLMENT FORM - TYPE OR PRINT CLEARLY**

**Name of Person to be Insured**  
 Last First Initial Social Security # Date of Birth Home Phone ( )

**Home Address**  
 City State Zip

**Name of Employer**  
 Business Phone Date of Hire Monthly Hours Worked ( )

**Employee Gender:**  Male  Female **Marital Status:**  Married  Single

**Name of Spouse :** Last First Initial Date of Birth Social Security #

Names of Dependent Children	Date of Birth	Sex	Social Security #

**Type of Coverage:**  Employee Only  Employee & Spouse  Employee & Child  Employee & Children  Employee, Spouse & Child(ren)

**Medical:** \_\_\_\_\_

**Dental:**  Yes  No **Vision:**  Yes  No

**Disability:**  Yes  No

<p><b>Have you had prior health insurance within the past 63 days? Yes <input type="checkbox"/> No <input type="checkbox"/></b></p> <p><b>If yes, name of prior carrier:</b> _____</p>
--

**Group Life Insurance:**  Smoker  Non-Smoker **Amount:**  \$10,000  \$25,000  \$50,000  \$75,000  \$100,000  Other

**Spouse:**  Smoker  Non-Smoker **Amount:**  \$10,000  \$25,000  \$50,000  \$75,000  \$100,000  Other

(Amounts in excess of \$25,000 require pre-approval)

**Dependent(s):**  None  One Unit (\$3,000)  Two Units (\$6,000)

**Beneficiary:** \_\_\_\_\_  
 Name Relationship Contingent

**Spouse Beneficiary:** \_\_\_\_\_  
 Name Relationship Contingent

<b>For Office Use Only</b>	
Effective Date: _____	Termination Date: _____
Class Change Date: _____	VGL Amount: _____
Disability Income Amount: _____	
<input type="checkbox"/> Original Group	<input type="checkbox"/> Special Enrollee
<input type="checkbox"/> New Employee	<input type="checkbox"/> Late Enrollee

\_\_\_\_\_  
**Employee Signature** **Date**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

## **WAIVER OF GROUP COVERAGE**

**(MUST BE COMPLETED IF ANY COVERAGE IS DECLINED OR REFUSED BY AN ELIGIBLE EMPLOYEE)**

EMPLOYEE NAME \_\_\_\_\_ SOCIAL SECURITY # \_\_\_\_\_ EMPLOYER NAME \_\_\_\_\_

- |   |   |
|---|---|
| <p><input type="checkbox"/> I WAIVE TOTAL COVERAGE FOR MYSELF<br/>(AND DEPENDENTS, IF ANY)</p> <p><input type="checkbox"/> I WAIVE HEALTH PLAN COVERAGE FOR MYSELF<br/>(AND DEPENDENTS, IF ANY)</p> <p><input type="checkbox"/> I WAIVE HEALTH PLAN COVERAGE FOR MY SPOUSE ONLY</p> <p><input type="checkbox"/> I WAIVE HEALTH PLAN COVERAGE FOR MY CHILDREN ONLY</p> | <p>REASON FOR DECLINING COVERAGE (CHECK ONE):</p> <p><input type="checkbox"/> COVERED BY SPOUSES COVERAGE</p> <p><input type="checkbox"/> COVERED BY CHAMPUS OR CHAMPVA</p> <p><input type="checkbox"/> COVERED BY HMO</p> <p><input type="checkbox"/> OTHER (EXPLAIN) _____</p> <p>_____</p> |
|---|---|

THIS IS TO ACKNOWLEDGE THAT THE AVAILABLE COVERAGES HAVE BEEN EXPLAINED TO ME BY MY EMPLOYER. I HAVE BEEN GIVEN THE OPPORTUNITY TO APPLY FOR THE AVAILABLE COVERAGES AND HAVE ELECTED NOT TO ENROLL MYSELF AND/OR MY DEPENDENTS, IF ANY.

**If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if employer contributions towards your or your dependent's other coverage terminate), provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself or your dependents, provided that you request enrollment within 31 days (60 days in Idaho) after the marriage, birth, adoption, or placement for adoption. To request such special enrollment, please contact Kay Harrison, Enrollment Department, (801) 263-8000 x104 or (800) 748-5340 x104.**

**X**  
\_\_\_\_\_  
EMPLOYEE SIGNATURE

\_\_\_\_\_  
DATE