WESTERN MUTUAL INSURANCE COMPANY P.O. Box 572450 ♦ Salt Lake City, Utah ♦ 84157-2450

ENROLLMENT FORM - Print clearly in ink.

Name of Employee ____________________
Last First Initial Social Security # Birth Date Home Phone

Mailing Address ____________________
Street City State Zip Business Phone Date of Hire Hours Worked Weekly

Employer ____________________ Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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

Names of Dependent Children	Sex	Birth Date	Social Security #

Type of Coverage: ☐ Employee Only ☐ Employee & Spouse ☐ Employee & Child ☐ Employee & Children ☐ Family

Medical: ____________________ Dental: * ☐ Yes ☐ No Vision:* ☐ Yes ☐ No Disability:* ☐ Yes ☐ No

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 ____________

* Dental, Vision, Disability and Life insurance are subject to employer election and approval. Life insurance amounts in excess of $25,000 require pre-approval.

Dependent Life: ☐ None ☐ One $3,000 Unit ☐ Two $3,000 Units ($6,000 total)

Beneficiary: ____________________
Name Relationship Contingent

Spouse's:
Beneficiary: ____________________
Name Relationship Contingent

____________________ ____________
EMPLOYEE SIGNATURE **DATE**

For Office Use Only

Effective Date: ________ Termination Date: ________
Class Change Date: ________ VGL Amount: ________
Disability Income Amount: ________
☐ Original Group ☐ Special Enrollee
☐ New Employee ☐ Late Enrollee

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

WMI EF (3/08) -- --

WAIVER OF GROUP COVERAGE

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

EMPLOYEE NAME ____________ SOCIAL SECURITY #____________ EMPLOYER NAME ____________

☐ I WAIVE ALL COVERAGE FOR MYSELF AND DEPENDENTS (IF ANY)

☐ I WAIVE HEALTH PLAN COVERAGE FOR MYSELF AND DEPENDENTS (IF ANY)

☐ I WAIVE HEALTH PLAN COVERAGE FOR MY SPOUSE ONLY

☐ I WAIVE HEALTH PLAN COVERAGE FOR MY CHILDREN ONLY

REASON FOR DECLINING COVERAGE (CHECK ONE):
☐ COVERED BY SPOUSE'S COVERAGE
☐ COVERED BY OTHER INSURANCE OR HMO
☐ COVERED BY CHAMPUS OR CHAMPVA
☐ OTHER (EXPLAIN) ____________________

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 after the marriage, birth, adoption, or placement for adoption. To request such special enrollment, please contact the Enrollment Department at (801) 263-8000 or (800) 748-5340.

____________________ ____________________
EMPLOYEE SIGNATURE **DATE**