

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 Plan: **Dental:** Yes No **Vision:** Yes No **Disability:** Yes No

Group Life Insurance: *(Amounts in excess of \$25,000 require pre-approval)*

Employee: 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

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

Beneficiary: Name Relationship Contingent

Spouse Beneficiary: Name Relationship Contingent

For Office Use Only

Effective Date: _____ Termination Date: _____
 Class Change Date: _____ VGL Amount: _____
 Disability Income Amount: _____
 Original Group Special Enrollee
 New Employee 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
(AND DEPENDENTS, IF ANY)</p> <p><input type="checkbox"/> I WAIVE HEALTH PLAN COVERAGE FOR MYSELF
(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 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