

LIFE INSURANCE ENROLLMENT / CHANGE FORM



FORT DEARBORN LIFE
Insurance Company

A Member of the Preferred Financial Group

Please Print

EMPLOYEE NAME - LAST		FIRST	MIDDLE INITIAL	GENDER M <input type="checkbox"/> F <input type="checkbox"/>
DATE OF BIRTH / /	DATE OF HIRE (FULL TIME) / /		DO YOU SMOKE? YES <input type="checkbox"/> NO <input type="checkbox"/>	
SOCIAL SECURITY NO. (THIS IS YOUR CERTIFICATE NO.)	EARNINGS \$	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually	JOB TITLE	CLASS <input type="checkbox"/> CLASSIFIED <input type="checkbox"/> CERTIFIED <input type="checkbox"/> MANAGEMENT
EMPLOYER Chabot-Las Positas Community College District	GROUP NO. / ACCOUNT NO. F006604-0001 / Class 1-01		LOCATION <input type="checkbox"/> District	<input type="checkbox"/> Chabot College <input type="checkbox"/> Las Positas College

<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> CHANGE - CHECK APPLICABLE ITEMS <input type="checkbox"/> NAME CHANGE: (GIVE PREVIOUS NAME) _____ <input type="checkbox"/> CHANGE OF BENEFICIARY <input type="checkbox"/> OTHER: (SPECIFY) _____
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COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you your cost, if any, and whether you will be required to complete a health questionnaire

BASIC COVERAGE

Basic Life/AD&D <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	LTD Benefit <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
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BENEFICIARY DESIGNATION (For Employee Only: Must Be Completed if you have applied for life or AD&D insurance). If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage).

FIRST NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY#	BENEFIT %
Primary					
Primary					%
Contingent					%
					%

I HEREBY REQUEST TO BE INSURED AND AUTHORIZE DEDUCTIONS, IF ANY FROM MY COMPENSATION FOR MY SHAR OF THE COST OF THE BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE GROUP POLICY (IES) ISSUED TO THE EMPLOYER LISTED ABOVE. I UNDERSTAND THAT IF I AM NOT ACTIVELY AT WORK AS DEFINED IN THE POLICY ON THE DATE MY COVERAGE WOULD OTHERWISE BECOME EFFECTIVE MY INSURANCE WILL NOT BEGIN UNTIL THE DAY I MEET THE POLICY DEFINITION OF ACTIVELY AT WORK. FOR THOSE COVERAGES I HAVE DECLINED I UNDERSTAND THAT IF I CHOOSE TO ENROLL AT A LATER DATE MY COST MAY BE HIGHER AND A HEALTH QUESTIONNAIRE MAY BE REQUIRED.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties (not enforceable in OR or VA).

EMPLOYEE SIGNATURE _____

DATE ____ / ____ / ____