

**ENROLLMENT
FORM**

Mail to:
Select Benefit Administrators of America
118 3rd Street East
P.O. Box 440
Ashland, WI 54806
1-800-497-3699

PART I – TO BE COMPLETED BY THE EMPLOYEE

Employee's Name (Last, First, Middle)		Social Security #	Date of Birth / /	Case Number 88653
Employee's Home Address			City	State
			Zip Code	Home Phone #
Employer's Name Universal Information Systems, Inc. DbA UNITEMP Temporary Personnel			Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Employment / /
Marital Status				
<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced/Legally Separated				
Do you have an eligible spouse?		Number of eligible Children:	Indicate eligible dependents you wish to insure:	
<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> None <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Spouse & Children	

DEPENDENT INFORMATION – Complete If You Are Requesting Family Coverage

No person can be insured under this policy as both an Employee and a dependent, or as a dependent of more than one Employee. Please complete the following information for each family member you wish to cover.

Dependents Name (Last, First, Middle)	Sex	Date of Birth	Relationship to Employee	Full-Time Student
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

BENEFICIARY DESIGNATION

PRIMARY (P) – The person(s) you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage (%) has not been designated, then each will receive an equal share of the benefit.

CONTINGENT (C) - The person(s) you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage (%) has not been designated, then each will receive an equal share of the benefit.

NOTE: The Group Policyholder may not be named as a Beneficiary.

BENEFICIARY DESIGNATION

Full Name & Address	Date of Birth	Relationship	Primary (P) Contingent (C)	% of Benefit

This Is Important – Please Read

A new Enrollment Form must be completed for any changes such as name change, beneficiary change, birth of a child, adoption of a child. The new form must be **dated, signed, and attached** to your original Enrollment Form.

This Election for Coverage Cannot Be Processed Unless All Questions Are Answered And The Form Is Signed And Dated.

DECLINATION OF INSURANCE

I have been given the opportunity to elect the Group Insurance Benefits as provided under a plan of Group Insurance established by my Employer. I have decided **NOT** to elect this coverage. I understand that if I decide to elect this insurance at a later date, satisfactory proof of insurability will be required at my expense.

Employee Signature

Date Signed

YES, I DO WANT THIS COVERAGE.

- I elect coverage for insurance for which I am or may become eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company.
- I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance. **(Not applicable if the Employer pays 100% of the required contribution).**
- I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death.
- All information submitted by me on this form at Symetra Life Insurance Company's request, to the best of my knowledge and belief, is true and complete.

Employee Signature

Date Signed

PART II – TO BE FILLED OUT BY THE EMPLOYER.

New Employee Late Entrant Enrollee Open Enrollment

Change Requests – Effective Date of Change ____/____/____ Effective Date of Coverage ____/____/____

Case Number 88653 Plan/Package Selected _____