RESET FORM

Life and Disability Income Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee.

Name of Employer/Plan Sponsor North American Division of Seventh-day Adventists		Group/Plan Number 67807-4	Account Number/Location	
Class/Occupation	Date of Hire *(mm/dd/yyyy)*	Annual Salary	Employment Status:	☐ Active Full-Time ☐ Active Part-Time
This change is due to: *(check all that apply)* ☐ Initial Eligibility Following Hire ☐ Change in Coverage Amount	☐ Late Entrant* ☐ Other: _____			Effective Date of Coverage or Change:

**A late entrant is an individual who is first enrolling for supplemental or dependent life income coverage after the first available opportunity.*

Employee Information

Employee Name *(last, first, middle initial)*	Date of Birth *(mm/dd/yyyy)*	Social Security #	Employee I.D. #
Employee Address *(street address, city, state, zip code)*	Work Phone Number	Home Phone Number	☐ Female ☐ Male

Disability Income Coverage

Monthly Income Benefits (LTD) *(Note: LTD coverage is employer provided.)*	☑ Elect Coverage – (Only Full-Time Employees are eligible for coverage)

Employee Life Insurance (Subject to a combined basic and supplemental plan maximum of $850,000.)

Basic Life *(Note: Basic Life insurance is employer provided and only available to Full-time Employees.)*	☐ Standard Plan – Employee ($100,000), Spouse ($50,000), and Child(ren) ($10,000) ☐ Waive – I waive the Standard Plan and elect Plan A or B (Employee please see your Human Resources Representative for Plan A or Plan B enrollment form)
Supplemental Life	When you are initially eligible for Supplemental Life Insurance you can elect the Guaranteed Issue (GI) Limit of $250,000 without Evidence of Insurability. Total Supplemental Life coverage up to $750,000 in $10,000 increments is available if you complete an Evidence of Insurability form subject to approval by ReliaStar Life. Minimum coverage amount is $10,000.
Supplemental Life Election	☐ Elect: $_____ *($10,000 increments)* ☐ Waive

Beneficiary Information *Designate your beneficiary(ies) below.*

Name of Beneficiary *(last name, first, middle initial)* ☑ Primary		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Name of Beneficiary *(last name, first, middle initial)* ☐ Primary ☐ Contingent		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Name of Beneficiary *(last name, first, middle initial)* ☐ Primary ☐ Contingent		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Dependent Spouse Life Insurance

Spouse Life	If you are covered for Supplemental Life you can elect Dependent Spouse coverage. When you are initially eligible for Dependent Spouse coverage you can elect up to the Guaranteed Issue (GI) Limit of $30,000 without Evidence of Insurability on your spouse. Total Dependent Spouse Life coverage up to $250,000 in $10,000 increments is available if your spouse completes an Evidence of Insurability form subject to approval by ReliaStar Life. Spouse coverage is limited to 100% of the employee's Supplemental Life coverage amount. Minimum coverage amount is $10,000.	
Spouse Name and Date of Birth	Spouse Name _____	Spouse Date of Birth _____
Spouse Life Election	☐ Elect: $_____ *($10,000 increments)* ☐ Waive	

Note: The employee is the beneficiary for any Dependent Spouse insurance coverage.

Dependent Child(ren) Life Insurance

Child(ren) Life	If you are covered for Supplemental Life you can elect Dependent Child(ren) coverage. When you are initially eligible for Dependent Child(ren) Life coverage you can elect from $1,000 to $25,000 in $1,000 increments on your children from birth to less than 26 years without Evidence of Insurability. Child(ren) coverage is limited to 100% of the employee's Supplemental Life coverage amount. Minimum coverage amount is $1,000.
Child(ren) Life Election	☐ Elect: $_____ *($1,000 increments)* ☐ Waive

Note: The employee is the beneficiary for any Dependent Child(ren) insurance coverage.

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

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

Employee's Signature	Date Signed *(mm/dd/yyyy)*

THIS IS NOT AN APPLICATION FOR INSURANCE.
It is an enrollment form for coverage under a group plan sponsored by your employer.