## Accidental Death & Dismemberment (AD&D) Insurance Enrollment Form INSTRUCTIONS: Top box to be completed by the Employer. Remainder to be completed by the Employee.

North American Division of Seventh-day Adventists   \$7807.4		be completed by the Employer. Rema			•				
Employee Address (street address, city, state, zip code)  Employee Address (street address, city, state, zip code)  Date of Hire  Employment  Active Feliphone:    Active Part-Time	Name of Employer North American Division of Seventh-day Adventists				Acc	count Number/Location			
Class/Occupation						Date of Birth	Social	Security #	
Class/Occupation	Employee Address (street address, city, state, zip code)					-			
Status:	0110		D-4611			•			
Change in Coverage Amount   Change:   Change:   Change in Coverage Amount   Coverage Amount   S 300.000   (enter amount)   (for eligible employees only)   Not Applicable	·		Date of Hire			Active Part-Time			
Interest	☐ Initial Eligibility Following Hire ☐ Other:						_		
Employee Supplemental AD&D Insurance  Supplemental Employee AVailable coverage for all Employees: \$10,000 to \$500,000 in \$10,000 increments.  I am applying for Supplemental Employee AD&D coverage of: \$	· <del></del> \								
Supplemental Employee   Available coverage for all Employees: \$10,000 to \$500,000 in \$10,000 increments.   1 am applying for Supplemental Employee AD&D coverage of: \$	(for eligible employees only) Not Applicable								
am applying for Supplemental Employee AD&D coverage of: \$	Employee Supplemental AD&D Insurance								
Supplemental Pilot Waive  Supplemental Pilot AD&D coverage for Pilots only: \$25,000 to \$125,000 in \$25,000 increments.  I am applying for Supplemental Pilot AD&D coverage of: \$		Employee Available coverage for all Employees: \$10,000 to \$500,000 in \$10,000 increments.							
AD&D Election   I am applying for Supplemental Pilot AD&D coverage of: \$	AD&D Election	Waive							
Waive   Waiv		Available coverage for Pilots only: \$25,000 to \$125,000 in \$25,000 increments.							
Beneficiary Information Designate your beneficiary(less) below.  Name of Beneficiary (last name, first, middle initial)  Address  Date of Birth  Social Security Number  Phone Number  Date of Birth  Social Security Number  Phone Number  Date of Birth  Date of Bi	AD&D Election	☐ Waive							
Name of Beneficiary (last name, first, middle initial)  Address  Date of Birth  Social Security Number  Phone Number  Date of Birth  Social Security Number  Phone Number  Benefit %  Date of Birth  Social Security Number  Phone Number  Dependent AD&D Insurance  Dependent AD&D  If you and your spouse are insured as employees under the Group Policy, either you or your spouse, but not both, can apply for Dependent's insurance on the same dependent children (your spouse would not be an eligible dependent). Dependent Spouse AD&D Coverage of: \$	NOTE: Pilots are eligible to elect both Supplemental Employee and Pilot AD&D coverage.								
Address  Date of Birth  Social Security Number  Phone Number  Dependent AD&D Insurance  Dependent AD&D Insurance  If you and your spouse are insured as employees under the Group Policy, either you or your spouse, but not both, can apply for Dependent's insurance on the same dependent children (your spouse would not be an eligible dependent). Dependent Spouse  AD&D Election  Dependent Children  AD&D Is mapplying for Dependent Spouse AD&D coverage of:  Waive  Dependent Children  AD&D Election  Dependent Children I am applying for Dependent Children AD&D coverage of:  Waive  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.  I 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.  Any person who knowingly or willfully presents a false or fraduulent claim for payment of a loss or benefit or who knowingly or willfully presents a false or fraduulent claim for payment of a loss or benefit or who knowingly or willfully presents a false or fraduulent claim for payment of a loss or benefit or who knowingly or willfully presents a false or fraduulent claim for payment of a loss or benefit or who knowingly or willfully presents a false or fraduulent claim for payment of a loss or benefit or who knowingly or willfully presents a false or fraduulent claim for payment of a loss or benefit or who knowingly or willfully presents a false or fraduulent claim for payment of a loss or benefit or who knowingly or willfully presents a false or fraduulent claim for payment of a loss or benefit or who knowingly or willfully presents a false or fraduulent claim for payment of a loss or benefit or who knowingly or willfully presents a false or fraduulent claim for payment of a loss or benefit or who knowingly or willfully presents a false or fraduulent claim for payment of a lo	Beneficiary Information Designate your beneficiary(ies) below.							D 51.0/	
Name of Beneficiary (last name, first, middle initial)  Primary Contingent Relationship to Employee Benefit %  Address  Date of Birth Social Security Number Phone Number  Phone Number  Dependent AD&D Insurance  If you and your spouse are insured as employees under the Group Policy, either you or your spouse, but not both, can apply for Dependent's insurance on the same dependent children (your spouse would not be an eligible dependent). Dependent coverage is limited to 100% of the elected amount of Supplemental Employee coverage.  Dependent Spouse   I am applying for Dependent Spouse AD&D coverage of: \$	Name of Beneficiary (last name, first, middle initial)			✓ Prim	ary	Relationship to Employee		Benefit %	
Name of Beneficiary (last name, first, middle initial)  Primary Contingent Relationship to Employee Benefit %  Address  Date of Birth Social Security Number Phone Number  Phone Number  Dependent AD&D Insurance  If you and your spouse are insured as employees under the Group Policy, either you or your spouse, but not both, can apply for Dependent's insurance on the same dependent children (your spouse would not be an eligible dependent). Dependent coverage is limited to 100% of the elected amount of Supplemental Employee coverage.  Dependent Spouse   I am applying for Dependent Spouse AD&D coverage of: \$									
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Dependent AD&D Insurance    Dependent AD&D	Name of Beneficiary (last name, first, middle initial)		Primary	☐ Conf	ingent	Relationship to Employee Benefit		Benefit %	
Dependent AD&D Insurance    Dependent AD&D									
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AD&D Election  Note: The employee is the beneficiary for any Dependent 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.  Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.		I am applying for Dependent Spouse AD&D coverage of: \$ (\$10,000 to \$500,000 in \$10,000 increments)							
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	<ul> <li>I authorize my employer</li> <li>To the best of my knowle</li> <li>I understand my coverage</li> <li>Any person who knowingly</li> </ul>	to deduct from my wages the premium edge and belief, the information I have ge begins on the effective date assigned y or willfully presents a false or fra	, if any, for the provided on the by ReliaStandulent class	the elected this form is tar Life, pro aim for pa	coverace correct vided I a yment	ge. t. am actively at work. <b>of a loss or benef</b> ii			