RESET FORM

# Accidental Death & Dismemberment (AD&D) Insurance Enrollment Form

*INSTRUCTIONS: Top box to be completed by the Employer. Remainder to be completed by the Employee.*

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|---|---|---|---|
| **Name of Employer**<br>**North American Division of Seventh-day Adventists** | **Group Number**<br>**67807-4** | **Account Number/Location** | |
| **Employee Name** *(last, first, middle initial)* ☐ Female ☐ Male | | **Date of Birth** | **Social Security #** |
| **Employee Address** *(street address, city, state, zip code)* | | **Work Telephone:**<br>**Home Telephone:** | |
| **Class/Occupation** | **Date of Hire** | **Employment Status:** | ☐ Active Full-Time ☐ Active Part-Time |
| **This change is due to:** *(check all that apply)*<br>☐ Initial Eligibility Following Hire ☐ Other: _____<br>☐ Change in Coverage Amount | | **Effective Date of Coverage or Change:** | |
| **Employer Paid Basic AD&D Insurance Amount:** $ 300,000 *(enter amount)*<br>*(for eligible employees only)* ☐ Not Applicable | | | |

## Employee Supplemental AD&D Insurance

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|---|---|
| **Supplemental Employee AD&D Election** | Available coverage for all Employees: $10,000 to $500,000 in $10,000 increments.<br>I am applying for Supplemental Employee AD&D coverage of: $_____.<br>☐ Waive |
| **Supplemental Pilot AD&D Election** | Available coverage for Pilots only: $25,000 to $125,000 in $25,000 increments.<br>I am applying for Supplemental Pilot AD&D coverage of: $_____.<br>☐ Waive |

*NOTE: Pilots are eligible to elect both Supplemental Employee and Pilot AD&D coverage.*

## 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** |
| | | | |

## Dependent AD&D Insurance

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|---|---|
| **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 coverage is limited to 100% of the elected amount of Supplemental Employee coverage. |
| **Dependent Spouse AD&D Election** | I am applying for Dependent Spouse AD&D coverage of: $_____. *($10,000 to $500,000 in $10,000 increments)*<br>☐ Waive |
| **Dependent Children AD&D Election** | I am applying for Dependent Children AD&D coverage of: $_____. *($5,000 to $25,000 in $5,000 increments)*<br>☐ Waive |

*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.**

| Employee's Signature | Date Signed |
|---|---|
| | |