Life and AD&D 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		Group/Plan Number	Account Number/Location
Contoocook Valley School District, SAU #1		67035-9	001
Class/Occupation	**Date of Hire** *(mm/dd/yyyy)*	**Annual Salary**	**Employment Status:** ☐ Active Full-Time
This change is due to: *(check all that apply)* ☐ Initial Eligibility Following Hire ☐ Late Entrant* ☐ Change in Coverage Amount ☐ Other: ______________			**Effective Date of Coverage or Change:**

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)	☑ Elect Coverage *(Note: LTD coverage is employer provided.)*

Employee Life & Accidental Death & Dismemberment (AD&D) Insurance

Basic Life & AD&D	☑ Employee Only—Elect Coverage *(Note: Basic Life & AD&D insurance is employer provided.)*

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**

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.

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