

Application to Transfer

Personal Plans

Return completed form to: Insurance Operations — Personal Plans
GuideStone Financial Resources, SBC
2401 Cedar Springs Road
Dallas, TX 75201-1498

Or fax form to: Insurance Operations — Personal Plans
214-720-2105

Note: If you are requesting additional coverage not in force at the time of transfer, evidence of good health is required. Call **1-888-98-GUIDE** (1-888-984-8433) or visit our Web site at www.GuideStoneInsurance.org to secure the necessary form.

1. PARTICIPANT INFORMATION

Participant name: _____ Social Security number: _____

Home address: _____

City: _____ State: _____ ZIP Code: _____

Home telephone: (_____) _____ Birth date: ____/____/____ Marital status: Married Single Widowed

Important: If your marital status has changed and/or information you previously provided to GuideStone is no longer correct, please attach copies of the appropriate document(s) to verify the change (i.e., marriage certificate, death certificate, divorce decree).

Total annual compensation: _____ Employment date: ____/____/____

E-mail: _____

2. EMPLOYER INFORMATION

Employer name: _____ Employer account number: _____

Employer's physical address: _____

City: _____ State: _____ ZIP Code: _____

Billing address if different from employer's physical address: _____

City: _____ State: _____ ZIP Code: _____

Association: _____

Continued on other side



3. APPLICANT AND DEPENDENT INFORMATION (LIST ALL FAMILY MEMBERS TO BE COVERED)

Last name (**Self**): _____ First name: _____ MI: _____
Social Security number: _____ Birth date: ____/____/____ Gender: Male Female
Relationship: Self Dental office number (Guided Dental HMO Plan only): _____ HMO PCP number: _____

Last name (**Spouse**): _____ First name: _____ MI: _____
Social Security number: _____ Birth date: ____/____/____ Gender: Male Female
Relationship: Spouse Dental office number (Guided Dental HMO Plan only): _____ HMO PCP number: _____

Last name (**Dependent**): _____ First name: _____ MI: _____
Social Security number: _____ Birth date: ____/____/____ Gender: Male Female
Relationship: Child Stepchild Grandchild
Dental office number (Guided Dental HMO Plan only): _____ HMO PCP number: _____

Last name (**Dependent**): _____ First name: _____ MI: _____
Social Security number: _____ Birth date: ____/____/____ Gender: Male Female
Relationship: Child Stepchild Grandchild
Dental office number (Guided Dental HMO Plan only): _____ HMO PCP number: _____

Last name (**Dependent**): _____ First name: _____ MI: _____
Social Security number: _____ Birth date: ____/____/____ Gender: Male Female
Relationship: Child Stepchild Grandchild
Dental office number (Guided Dental HMO Plan only): _____ HMO PCP number: _____

Last name (**Dependent**): _____ First name: _____ MI: _____
Social Security number: _____ Birth date: ____/____/____ Gender: Male Female
Relationship: Child Stepchild Grandchild
Dental office number (Guided Dental HMO Plan only): _____ HMO PCP number: _____

Last name (**Dependent**): _____ First name: _____ MI: _____
Social Security number: _____ Birth date: ____/____/____ Gender: Male Female
Relationship: Child Stepchild Grandchild
Dental office number (Guided Dental HMO Plan only): _____ HMO PCP number: _____

Dependent child must be under age 25, not married and dependent on you for support and maintenance.

Make copies of this page and complete if more dependents will be covered.

4. BENEFICIARY DESIGNATION

Employee term life insurance (and AD&D if applicable)	Relationship	Birth date	Social Security number
Primary beneficiary:*	_____	____/____/____	_____
Primary beneficiary:*	_____	____/____/____	_____
Secondary beneficiary:*	_____	____/____/____	_____
Secondary beneficiary:*	_____	____/____/____	_____

Personal accident insurance

Primary beneficiary: * _____ / ____ / ____

Secondary beneficiary: * _____ / ____ / ____

* Show full given name

If you name more than one beneficiary, settlement will be made in equal shares to the designated beneficiaries that survive you unless otherwise provided in the designation. If no named beneficiary survives, your settlement will be made in accordance with the group contract.

5. SIGNATURE

Applicant signature: _____ Date signed: ____/____/____

6. COVERAGE OPTIONS

Previous employer: IMB NAMB

Service dates: Hire date: ____/____/____ Termination date: ____/____/____

Employee term life options (Coverage cannot exceed \$750,000.)

- | | | | | |
|---|---|----|-----------------------------------|------------------------------------|
| <input type="checkbox"/> 1 times salary | <input type="checkbox"/> 5 times salary | OR | <input type="checkbox"/> \$10,000 | <input type="checkbox"/> \$35,000 |
| <input type="checkbox"/> 2 times salary | <input type="checkbox"/> 6 times salary | | <input type="checkbox"/> \$15,000 | <input type="checkbox"/> \$40,000 |
| <input type="checkbox"/> 3 times salary | <input type="checkbox"/> 7 times salary | | <input type="checkbox"/> \$20,000 | <input type="checkbox"/> \$45,000 |
| <input type="checkbox"/> 4 times salary | <input type="checkbox"/> 8 times salary | | <input type="checkbox"/> \$25,000 | <input type="checkbox"/> \$50,000 |
| | | | <input type="checkbox"/> \$30,000 | <input type="checkbox"/> \$100,000 |

Accidental death & dismemberment Yes No
(Equals employee life amount.)

Spouse term life insurance Yes No

Coverage amount \$ _____
(Must be in \$5,000 increments not to exceed 50% of your coverage.)

Child term life insurance (\$10,000) Yes No

Personal accident insurance

For myself Yes No

Coverage amount: \$ _____
(Available to employee in \$25,000 increments to maximum of \$500,000.)

For my spouse

Yes No

(Coverage for spouse equals 50% of your coverage.)

Disability

Long-term disability

Short-term disability

- Economy
- Choice
- Premier

- Economy
- Choice

6. COVERAGE OPTIONS (CONTINUED)

Dental benefits

Check the options that apply for dental benefits:

- For myself For spouse For eligible children

Select one dental plan:

- Premier Dental Care Plan
 Choice Dental Care Plan
 Guided Dental HMO Plan (If selecting this plan, indicate a dental office number in Section 3 for each covered person.)

Medical benefits

Check the options that apply for medical benefits:

- For myself For spouse For eligible children

Select a medical plan option for yourself and/or any covered dependent who is Medicare primary:

- Senior Plus Plan
 Senior Plan

Select a medical plan option for yourself or any covered dependent who is NOT Medicare Primary:

- | | |
|---|--|
| <input type="checkbox"/> Health Today | <input type="checkbox"/> Health Saver 2600 |
| <input type="checkbox"/> Health Choice 500 | <input type="checkbox"/> Health Legacy 200 |
| <input type="checkbox"/> Health Choice 1000 | <input type="checkbox"/> Health Select 200* |
| <input type="checkbox"/> Health Choice 2000 | <input type="checkbox"/> Health Select 500* |
| <input type="checkbox"/> Health Choice 3000 | <input type="checkbox"/> Health Select 2000* |

* Only available in certain areas.

7. SIGNATURE OF NAMB/IMB AUTHORIZED REPRESENTATIVE

Signature: _____ Date signed: ____/____/____