

Group Plans Enrollment Form

A. GENERAL INFORMATION (ALL SPACES MUST BE COMPLETED)

Employer name: _____ Employer number: _____

Employee name: Last: _____ First: _____ MI: _____

Birth date: ____/____/____ Social Security number: _____

Home address: _____

City: _____ State: _____ ZIP Code: _____

Daytime telephone: (____) _____ Email: _____

Sex: Male Female Marital status: Married Single Employee classification: _____

Monthly salary: _____ Date of full-time employment: ____/____/____ Coverage effective date: ____/____/____

B. BENEFIT ELECTION

Term life insurance

Employee life (employer base): Yes No

Amount*: \$ _____

Employee optional life insurance** Yes No

Spouse life insurance (employer base) Yes No

Spouse optional life insurance** Yes No

Child life insurance Yes No

* If employer base life salary multiple is greater than 4, separate application is required.

**Requires separate application

AD&D Yes No

Disability plans

Short-term disability plan Yes No

Economy Short Term Disability

Choice Short Term Disability

Premier Short Term Disability

Long-term disability plan Yes No

Economy Long Term Disability

Choice Long Term Disability

Premier Long Term Disability

Personal accident insurance

For myself Yes No

Amount \$ _____

For my spouse Yes No

Amount \$ _____ (50% of employee volume)

Medical benefits

For myself Yes No

For spouse Yes No

For eligible children Yes No

Coverage (Check one):

Health Legacy 200

Health Today

Health Choice 500

Health Choice 1000

Health Choice 2000

Health Choice 3000

Health Choice 5000

Health Saver 2600

Health Saver 2800

Health Saver 3000

Health Select/Out-of-area

200 500 1000

2000 3000 5000

Senior plans

Senior Plan

Senior Plus Plan

Care Basic Plan

Care Plus Plan

Note: The Senior Plan Enrollment Form is required for all Senior and Care Plans. The coverage effective date depends on the date this form is received.

Dental plans

For myself Yes No

For spouse Yes No

For eligible children Yes No

Coverage (check one):

Premier Dental Care

Choice Dental Care

Guided Dental HMO*

*Dental office ID number required, please provide on page 2.

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Employee name: _____ Social Security number: _____

C. PARTICIPANT & DEPENDENT* INFORMATION (ONLY LIST FAMILY MEMBERS TO BE COVERED)

Last name	First name	Initial	Social Security number	Relationship	Birth date	Sex M/F	Medical Yes/No	Dental Yes/No	Dental ID number (Guided Dental only)
			_____	Self	_____	—			

* Your spouse and children up to age 26 are eligible for coverage.

D. BENEFICIARY DESIGNATION

(This beneficiary designation is only applicable to your Life, AD&D and Employee Personal Accident benefits)

Life insurance (and AD&D if applicable)	Relationship	Birth date	Social Security number
Primary beneficiary:*	_____	___/___/___	_____
Primary beneficiary:*	_____	___/___/___	_____
Secondary beneficiary:*	_____	___/___/___	_____
Secondary beneficiary:*	_____	___/___/___	_____

Employee personal accident insurance	Relationship	Birth date	Social Security number
Primary beneficiary:*	_____	___/___/___	_____
Primary beneficiary:*	_____	___/___/___	_____
Secondary beneficiary:*	_____	___/___/___	_____
Secondary beneficiary:*	_____	___/___/___	_____

*show full given name

E. REQUIRED SIGNATURES

I authorize my employer to arrange for me to be covered under the terms of the plans I have chosen. I also authorize my employer to make any required deductions from my earnings as my contribution to the cost of this coverage.

Employee signature: _____ Date: ___/___/___

Employer representative: _____ Date: ___/___/___

GUIDESTONE USE ONLY

Processed by: _____ Date: ___/___/___ PCL: _____ Letter: _____