Enrollment Form

for group term life and/or disability coverage

Instructions: attach form AICK 4EV if a Late Enrollee
or requesting more than the Guarantee Issue amount.

Your employer is:________________________ **AICK group no**.________________________
Class

Section 1 – Employee and employment information

Last name ____ First name ____ MI ____ Suffix ____

Residential address ____ City ____ State ____ Zip ____ +4 ____

Birth date ____ Gender: ☐ Male ☐ Female Social security number ____ Date of hire ____

Employee Occupation/Job Title ____

Your phone number: ☐ Home/Cell ____ (Area code + number) ☐ Work ____ (Area code + number)

I am actively at work performing all my job duties: ☐ Yes ☐ No **and** I work ____ (indicate number) hours weekly for this employer.

$____ ☐ HR ☐ WK ☐ MO ☐ ANN Base earnings (do not include commission, bonuses, overtime or any other extra compensation except as shown in the group policy)

Check one:

☐ I am a new employee enrolling at my first opportunity.

☐ I am a rehired employee. Rehire date: ____

☐ I am an existing employee enrolling due to: Date of occurrence (of the event checked below) ____

☐ Temporary to permanent ☐ Other (explain) ____

I am enrolling in:

Basic term life and AD&D	Dependent life	Short term disability	Long term disability
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Are you married? ☐ Yes ☐ No Date of marriage ____

Do you have unmarried dependent children under 23 years of age? ☐ Yes ☐ No

Section 2a – Your primary beneficiary

The **primary beneficiary receives the benefit upon your death**. If you name two or more primary beneficiaries, the proceeds will be paid in equal shares unless stated otherwise. If you need more space, attach a separate sheet with complete information that **you have signed and dated.**

First name ____ MI ____ Last name ____ Suffix ____

Relationship to applicant ____ Date of birth or age ____

First name ____ MI ____ Last name ____ Suffix ____

Relationship to applicant ____ Date of birth or age ____

You must sign and date page 2

For office use only: Group # ____ Subgroup # ____ Class ____

☐ STD ☐ LTD Subscriber # ____

An independent licensee of the Blue Cross Blue Shield Association.

Section 2b – Your contingent beneficiary

A contingent beneficiary **receives the benefit only if the primary beneficiary(ies) listed in the previous section is (are) deceased.** If you need more space, attach a separate sheet with complete information **that you have signed and dated.**

First name ____ MI ____ Last name ____ Suffix ____

Relationship to applicant ____ Date of birth or age ____

First name ____ MI ____ Last name ____ Suffix ____

Relationship to applicant ____ Date of birth or age ____

First name ____ MI ____ Last name ____ Suffix ____

Relationship to applicant ____ Date of birth or age ____

Section 2c – Beneficiary tips

1. This form must be signed, dated, **and received by AICK's Home Office** to be considered valid.
2. Payment cannot be made to children under 18 years of age. Benefits to minor children must be paid to a court-appointed conservator or guardian.
3. An insured cannot name their employer as a beneficiary.
4. Charities or churches may be named and must include the legal name and complete address.
5. Attach a separate sheet containing complete beneficiary information **that you have signed and dated** if the primary or contingent sections did not provide sufficient space to do so.

Section 3 – Dependent life beneficiary (if enrolling and applicable to your group's benefit plan)

You (the employee) will be beneficiary in the event of a payment of a dependent life benefit unless stated otherwise in writing.

Section 4 – Your authorization

I understand that if I am not at work on the effective date of the coverage, this coverage will not begin until the day I return to active work. I understand that to be insured I must be actively at work 1) performing all the normal duties of my job, 2) at the usual place, 3) for the required hours each week as stated in the group policy. I authorize the necessary payroll deductions from my earnings and designate the beneficiary(ies) named on this form to receive the benefit payable in the event of death. I believe that all persons for whom I am requesting coverage are resident citizens of the U.S.A. or are aliens legally residing in the U.S.A.; and that the information which I have provided on this form is true and correct as it pertains to my status with the named employer.

Your signature required

Employee's signature ____ Date signed ____

Print your name ____