Enrollment Form for Group Policy #615939-B
Additional Life Insurance (Plan 2)
Standard Insurance Company

Enrollment

Employee Name: _____

Social Security #: _____-____-_____ Date of Birth: _____/___/_____

Date of Hire: _____/____/_____

Additional Life: Coverage Amount Elected _____ $25,000.00
_____ $40,000.00

Application for Insurance: I authorize deduction from my Harrison Flexible Benefits account to cover the cost of my insurance.

_____/_____/_____
Signature Date

Beneficiary Designation

Below you are designating your beneficiary(ies) for the Additional Life Insurance coverage. There is a separate beneficiary designation for your Harrison Life Insurance benefits (Plan 1). Should you not name a beneficiary for this coverage, benefit payment will be made as provided under the terms of the policy.

Beneficiary Name **Address** **Social Security #** **Relationship**

_____
Primary

_____
Primary

_____
Contingent

_____
Contingent

I certify that I am not a key employee for any employer as defined as a person who, during the plan year or the preceding four years: 1) earned at least $45,000 and was an officer, 2) earned more than $30,000 and was 1 of the 10 employees owning the largest interest in the business, 3) owned more than 5% of the business, or 4) earned more than $150,000 and owned more than 1% of the business. I also certify that I am not covered by another group term life program outside of the Harrison Electrical Workers health and Welfare Trust.

_____/_____/_____
Signature Date

Note: Beneficiary designation is not valid unless this form is signed and dated.

White: Standard Insurance Yellow: Trust Office Pink: Employee