|  |  |
| --- | --- |
| Employer Name : ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Location \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ***Enrollment Data Collection Form*** |

**Employee Information**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name | | | | 🞎 Male 🞎 Female | | Social Security No. | | | Date of Birth | |
|  | | | |  | | |  | |
| Home Address | | | | | | | | | | Home Phone |
|  | | | | | | | | | |  |
| City | | | | State | | | | Zip Code | | Work Phone/Ext. |
|  | | | |  | | | |  | |  |
| Email Address | | | Do you agree to receive correspondence about your coverage electronically? 🞎 Yes 🞎 No | | | | Have you used tobacco products in the last year?🞎 No 🞎 Yes | | | |
| Hire Date | Are you actively at work? | Hours Worked per Week | | | Annual Salary | | | | Employee ID | |
|  | 🞎 No 🞎 Yes |  | | |  | | | |  | |

**Dependent Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Full Name of Dependents Coverage is Requested For | Gender | Relationship to Employee | Date of Birth | Social Security No. | Adults: Have you used tobacco products in the past year? |
|  | 🞎 Male  🞎 Female |  |  |  | 🞎 No 🞎 Yes |
|  | 🞎 Male  🞎 Female |  |  |  | **Does not apply to children** |
|  | 🞎 Male  🞎 Female |  |  |  |

**Beneficiary Designation** *(Employee will be the beneficiary for any dependent coverage. Each Beneficiary should equal 100%)*

|  |  |  |  |
| --- | --- | --- | --- |
| Primary Beneficiary: | | Relationship: | Percentage: |
|  |  |  |  |
| Contingent Beneficiary: | | Relationship: | Percentage: |
|  |  |  |  |

**Benefit Selections** *(underwritten by Transamerica Life Insurance Company)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Life Insurance** | | | **Accident Insurance** | | |
| **Coverage**  🞏Employee  🞏 Child  🞏 Spouse  **Total Premium =** | **Benefit Amount**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Monthly Premium**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **Coverage**  🞏 Individual  🞏 Single Parent Family  🞏 Two Adult Family  🞏 Family | **Plan Selection (Option 1 / Option 2)**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Monthly Premium**  \_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 🞏 Waive Coverage\* | | | 🞏 Waive Coverage\* | | |

**\*\*See Life insurance and Accident Plan brochures for benefit amount choices and monthly premium amounts\*\***

|  |  |  |  |
| --- | --- | --- | --- |
| **Mother’s Maiden Name** | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | **State Born**  **Date of Marriage** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Deduction Authorization:**

|  |
| --- |
| I authorize my employer to deduct from my earnings such amounts as may now or hereafter be payable by me under the insurance plan purchased. In the event of rate change, I authorize a corresponding change in the amount deducted from my earnings. In addition, I understand that any pre-tax elections cannot be changed or revoked prior to the next plan anniversary date, unless due to a change in family status and permitted by my employer.  **Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |