|  |  |
| --- | --- |
| 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |