Life and AD&D Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. All new coverage or any increases in Life coverage will require evidence of insurability (proof of good health) if plan participation requirements are not met. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

Name of Employer/Plan Sponsor: Firelands Regional Medical Center			Group/Plan Number: 64575-3	Account Number/Location:
Class/Occupation:	Date of Hire:	Annual Salary:	Employment Status: _____ Active Full-Time _____ Active Part-Time	
This change is due to: (Check all that apply): ___ Change in Coverage Amount ___ Initial Eligibility Following Hire ___ Late Entrant* ___ Other: ____________________			Effective Date of Coverage or Change:	

*A late entrant is an individual who is first enrolling for supplemental or dependent coverage after the first available opportunity.

Employee Information

Employee Name (last, first, middle initial):	___ Female ___ Male	Date of Birth:	Social Security #:	Employee I.D. #:
Employee Address (street address, city, state, zip code):			Telephone: Work: ( ) Home: ( )	

Employee Life Insurance

Basic Life	_X_ Employee Only - Elect Coverage (Note: Basic life insurance is employer provided.)

Employee Accidental Death & Dismemberment Insurance

Basic AD&D	_X_ Employee Only - Election Coverage (Note: Basic AD&D insurance is employer provided.)
Supplemental AD&D Election	___ Amount equal to supplemental life insurance coverage up to $500,000. ___ Waive

Beneficiary Information

Name of Beneficiary (last name, first middle initial)	Relationship to Employee	Benefit % (Must total 100%

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW:

- I authorize my employer to deduct from my wages the premium, if any, for the election of coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee's Signature:	Date Signed: