Employer Name: Siloam Springs School District #21	Group Plan Number: **00543228** **DOH:**	**Benefits Effective:**
Name:		Social Sec#
Address:		Phone:
Email address:	Are you married? Y or N	Date of birth:
Annual Salary_____ Have you used tobacco products in the last year? Yes or No	Please circle: Initial Enrollment Family Status Change	Male or Female

ELECTIONS FOR ***GUARDIAN*** VOLUNTARY PRODUCTS:

_____

SHORT TERM DISABILITY

☐ $_____ PER **WEEK** BENEFIT – Monthly deduction $_____ ☐ OR ⊘ ***DECLINE***

LONG TERM DISABILITY

☐ $_____ PER **MONTH** BENEFIT –Monthly deduction $_____ ☐ OR ⊘ ***DECLINE***

VOLUNTARY ACCIDENTAL ONLY DEATH/DISMEMBERMENT

☐ **$**_____ **Employee $**_____ **Spse $ 10k Child(ren)** ☐ OR ⊘ ***DECLINE***
$ _____ $_____ $_____ Monthly deductions Total:_____

VOLUNTARY TERM LIFE (Age Banded)

☐ **$**_____ **Employee $**_____ **Spse $ 10k Child(ren)** ☐ OR ⊘ ***DECLINE***
$_____ $_____ $_____ Monthly deductions Total:_____

If electing coverage on spouse and/or children, please complete:
Spouse Name:_____ Gender M/F
Date of Birth: _____
Address (if different from yours):_____
Phone:_____ Has spouse used tobacco products in the last year? Yes or No

Child Name:_____ Gender M/F
Date of Birth:_____
Address (if different from yours):_____
Phone:_____

Child Name:_____ Gender M/F
Date of Birth:_____
Address (if different from yours):_____
Phone:_____

➘ **Signature** _____ **Date**_____

IMPORTANT: Complete beneficiary designation on page 2 if electing ADD/Life.

Employer Name: Siloam Springs School District#21	Group Plan Number: **00543228**	#21
Name:	Social Security #	Social Sec#

Name your beneficiaries: (Primary beneficiary percentages must total 100%)

Primary Beneficiaries:

Name:_____ _____%

Address/City/State/Zip:_____

Phone:_____ Relationship to Employee:_____

Name:_____%

Address/City/State/Zip:_____

Phone: _____Relationship to Employee:_____

Contingent Beneficiary:_____ _____%

Address/City/State/Zip:_____

Phone: _____Relationship to Employee:_____

Contingent Beneficiary:_____ _____%

Address/City/State/Zip:_____

Phone: _____Relationship to Employee:_____

- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability. Guardian or its designee has the right to reject your request.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- I attest that the information provided above is true and correct to the best of my knowledge.

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New York require the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

Signature _____ **Date**_____