WBP NAMIC® WELFARE BENEFIT PLAN

ENROLLMENT/CHANGE FORM

Company Number

Company Name

First of the month start date. Wait periods selected by your company will apply

- ☐ New Employee
- ☐ Plan Change *(name, address or termination)*
- ☐ Dependent Change
- ☐ Beneficiary Change

Qualifying Event Date: ____________________

- ☐ Marriage/Divorce
- ☐ Newborn
- ☐ Loss Coverage

Effective Date: ____________________

Termination Date ____________________

PERSONAL INFORMATION

Employee Last Name | First Name | MI | Social Security Number | Phone Number

Mailing Address | Email Address

City | State | Zip or Postal Code | Date of Birth

Date of Hire/ Appointed to Board | Base Annual Salary | Bonus or Commission

☐ Employee ☐ Director | ☐ Male ☐ Female

(Check boxes that apply)

COVERAGES

All Coverages listed may not be offered by your company

Life Insurance

- ☐ Group Life
- ☐ Dependent Life
  - ☐ Spouse
  - ☐ Children
  - ☐ Waive
- ☐ Voluntary Life
  - Employee ____________
  - Spouse ____________
  - Children ____________
  - ☐ Waive
- ☐ Voluntary AD&D
  - Employee ____________
  - Spouse ____________
  - Children ____________
  - ☐ Waive

Disability Insurance

- ☐ Long Term Disability
  - ☐ Waive
- ☐ Short Term Disability
  - ☐ Waive

Vision Insurance

- ☐ Employee
- ☐ Employee/Spouse
- ☐ Employee/Children
- ☐ Family
- ☐ Waive

Dental Insurance

- ☐ High Plan
- ☐ Low Plan

- ☐ Employee
- ☐ Employee/Spouse
- ☐ Employee/Children
- ☐ Family
- ☐ Waive

Voluntary Insurance*

- ☐ Accident Insurance
  - ☐ Waive
- ☐ Critical Illness Insurance
  - ☐ Waive

*Must complete Lincoln application

NOTES

NAMIC® WELFARE BENEFIT PLAN

ENROLLMENT/CHANGE FORM

DEPENDENTS

Complete only if electing dependent coverage

Name	Gender	Date of Birth	Social Security Number	Relationship to Employee	Address if Different

BENEFICIARY INFORMATION

Primary Beneficiary Designation

Name	Address	Relationship	Benefit %

Contingent Beneficiary Designation (Attach Separate Sheet if Necessary)

Name	Address	Relationship	Benefit %

EMPLOYEE: PLEASE READ, SIGN AND DATE BELOW

I certified that all statements are true to the best of my knowledge and belief. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. (Please refer to your certificate for the exclusions that apply to your coverage.) I understand that in the event that I desire to request Long Term Disability, Short Term Disability, Dependent Life, and Voluntary Additional Life at a later date, I may be required to furnish, at my own expense, evidence of insurability satisfactory to the Insurance Company, and the Insurance Company will have the right to refuse my request.

Employee / Director Signature: ______________________ ______________

Company Benefit Administrator Approval: ______________________ ______________

Please complete and return by mail or fax:

NAMIC Welfare Benefit Plan

P.O. Box 68700 | Indianapolis, IN 46268-0700

Fax: 317-415-0158 | Phone: 800-336-2642

**The life insurance benefit does not include bonuses, commissions, and tips and tokens, overtime pay or any other fringe benefits or extra compensation.
Life benefits will be paid according to the provisions of the policy.