NAMIC
NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES

NAMIC Group Insurance Trust
Enrollment/Change Form

Company Number ________ Company Name ____________________

☐ New Employee | Qualifying Event Date ________ | Effecitve Date ____________

☐ Plan Change (name, address or termination) | ☐ Marriage/Divorce

☐ Dependent Change | ☐ Newborn | Termination Date ____________

☐ Beneficiary Change | ☐ Loss Coverage

Personal Information

Employees Last Name	First Name MI	Social Security Number	Date of Hire / Appointed to Board

Address	City State Zip Code	Date of Birth

Email address	Base Annual Salary	Employee (Check Box)	Director (Check Box)	Male Female (Check Boxes)

Coverages

Life Insurance

☐ Group Life
☐ Dependent Life
- ☐ Spouse
- ☐ Children
- ☐ Waive

☐ Voluntary Life (please list the dollar amount requested)
- Employee ____________
- Spouse ____________
- Children ____________
- Waive ____________

☐ Voluntary AD&D (please list the dollar amount requested)
- 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

Dependents

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

Beneficiary Information

Primary Beneficiary Designation			
Full Name	Address	Relationship	Benefit %
Contingent Beneficiary Designation (Attach Separate Sheet if Necessary)			
Full 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 appy 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 ______________________ **Date:** ______________

(Required)

Company Benefit Administrator Approval ______________________ **Date:** ______________

(Required)

If no changes are required, no action is needed. Current benefits will renew automatically. If you wish to make any coverage changes, please submit your enrollment forms to the NAMIC office by Dec, 31, 2017.

Please complete and return by mail or fax:

NAMIC Group Insurance Trust
PO Box 68700
Indianapolis, IN 46268-0700
Fax: 317-415-0194 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.**