NAMIC® WELFARE BENEFIT PLAN

ENROLLMENT/CHANGE FORM

Company Number

Company Name

☐ 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 | Email Address

Mailing 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

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

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ENROLLMENT/CHANGE FORM

DEPENDENTS

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

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.