Life Enrollment for Existing Employees and/or Beneficiary Designation Form

INSTRUCTIONS:
Please complete this form and return it to your Group Administrator. Your employer will retain a copy for your file and will send the original to BC Life & Health Insurance Company. Please also retain a copy of this form for your personal records.

1. PERSONAL INFORMATION

- ☐ Addition of $15,000 Term Life and AD&D Coverage *(complete sections 1, 2, 3 and 5)*
- ☐ Change of Beneficiary *(complete sections 1, 3 and 5)*
- ☐ Decline Life Coverage *(complete sections 1 and 4)*

LAST NAME	FIRST NAME	M.I.	SEX	GROUP NO.	SOCIAL SECURITY NO.

HOME ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE NO.	JOB TITLE	EMPLOYER NAME
( )		

2. DEPENDENT INFORMATION

SEX	LAST NAME	FIRST NAME	M.I.	BIRTHDATE MONTH DAY YEAR
☐ Male ☐ Female	Spouse			
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				
☐ Son ☐ Daughter				

3. BENEFICIARY INFORMATION – *Applies for all products unless otherwise noted.*	RELATIONSHIP	AGE (if minor)	PERCENTAGE
NAME OF PRIMARY BENEFICIARY			
ADDRESS OF PRIMARY BENEFICIARY			
NAME OF SECONDARY BENEFICIARY			
ADDRESS OF SECONDARY BENEFICIARY			

4. DECLINATION OF COVERAGE – *Signature required if declining Life Coverage.*

I acknowledge that the available Life Coverage has been explained to me by my employer and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any. **BY DECLINING THIS GROUP LIFE COVERAGE, I ACKNOWLEDGE THAT MY DEPENDENT(S) AND I MAY FORFEIT ANY OFFER OF GUARANTEED COVERAGE. I UNDERSTAND THAT ANY FUTURE LIFE APPLICATION MAY BE SUBJECT TO MEDICAL UNDERWRITING.**

X _____ _____

*Signature **if declining coverage for employee/dependent(s)*** *Date (Month / Day / Year)*

5. EMPLOYEE AUTHORIZATION – *Signature required*

I AM APPLYING FOR GROUP TERM LIFE & AD&D COVERAGE: I agree that all information on this form is correct and true. I authorize my employer to deduct from my earnings the contribution (if any) required to apply toward the cost of this plan. I certify that I am working at the employer's place of business in permanent employment.

I understand that my employer's application will determine coverage and that there is not coverage unless and until this application and an application made by my employer have been accepted and approved by BC LIFE & HEALTH INSURANCE COMPANY.

I AM CHANGING MY BENEFICIARY: I hereby revoke any current designations and change my beneficiary(s) to those listed herein. I alone am responsible for having read and completed the beneficiary information.

X _____ _____

Signature required *Date (Month / Day / Year)*