Clear
Save
Print

SYMETRA FINANCIAL

Mailing Address:
Symetra Life Insurance Company
Group Division
PO Box 34690
Seattle, WA 98124-1690

LIFE INSURANCE ENROLLMENT FORM

TO BE COMPLETED BY THE EMPLOYER

POLICY # _____

EMPLOYER/POLICYHOLDER NAME: _____

STREET ADDRESS | **CITY** | **STATE** | **ZIP CODE**

EMPLOYEE OCCUPATION/JOB TITLE

EMPLOYEE DATE OF EMPLOYMENT

EFFECTIVE DATE OF COVERAGE

FULL OR PART TIME EMPLOYEE

$ _____ **/** ☐ **HR** ☐ **WK** ☐ **MO** ☐ **YR**
BASIC EARNINGS

CLASS NUMBER (IF APPLICABLE)

I. EMPLOYEE INFORMATION

SEX ☐ **M** ☐ **F**

NAME

STREET ADDRESS | **CITY** | **STATE** | **ZIP CODE**

HOME TELEPHONE NUMBER | **DATE OF BIRTH** | **MARITAL STATUS**

II. BENEFITS: PLEASE CHECK IF YOU WISH TO ENROLL AND INCLUDE BENEFIT AMOUNT

Employee Life:	☐ YES	☐ NO	X BAE*	OR	$
Employee AD&D:	☐ YES	☐ NO	X BAE*	OR	$
Employee Supplemental Life:	☐ YES	☐ NO	X BAE*	OR	$
Employee Supplemental AD&D:	☐ YES	☐ NO	X BAE*	OR	$
Dependent Life:					
Spouse:	☐ YES	☐ NO	X BAE*	OR	$
Child:	☐ YES	☐ NO	X BAE*	OR	$
Spouse & Child:	☐ YES	☐ NO	X BAE*	OR	$
Dependent AD&D:					
Spouse:	☐ YES	☐ NO	X BAE*	OR	$
Dependent Supplemental Life:					
Spouse:	☐ YES	☐ NO	X BAE*	OR	$
Child:	☐ YES	☐ NO	X BAE*	OR	$
Spouse & Child:	☐ YES	☐ NO	X BAE*	OR	$
Dependent Supplemental AD&D:					
Spouse:	☐ YES	☐ NO	X BAE*	OR	$
Other:	☐ YES	☐ NO	X BAE*	OR	$
Other:	☐ YES	☐ NO	X BAE*	OR	$
Other:	☐ YES	☐ NO	X BAE*	OR	$

**** BAE: Basic Annual Earnings as defined in your contract***

LG-12011/CA 7/06

III. BENEFICIARY DESIGNATION

Definitions:

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

NAME	ADDRESS	D.O.B	RELATIONSHIP	PRIMARY	CONTINGENT	% OF BENEFIT

IV. SELECTION/WAIVER OF GROUP INSURANCE

I, the undersigned, an employee of the above-named policyholder, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance **(Not applicable if the [Employer] pays 100% of the required contribution).**

I hereby waive my right at this time to elect the insurance coverages which I did not select above. I understand that if I do not enroll within 31 days, when first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death.

All information submitted by me on this form to the best of my knowledge and belief is true and complete.

EMPLOYEE SIGNATURE **DATE SIGNED**

Please read the following notice that we are required by law to give to you.

For your protection California law requires the following to appear: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in a state prison.