

**To Be Completed By Human Resources**

Group Number <b>160906</b>	Division	Billing Category	Date of Employment
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**To Be Completed By Applicant**     Apply for Coverage     Beneficiary Change *Complete Beneficiary Section below.*     Name Change  
 Add or  Delete Dependent    Date of add/delete \_\_\_\_\_

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Your Address	City	State	ZIP
Former Name (Last, First, Middle) <i>Complete only if name change</i>		Phone Number	
Employer Name <b>Nodak Insurance Company</b>		Job Title/Occupation	
Hours Worked Per Week	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		

**Coverage** *Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.*

**Life Insurance**

Basic Life with AD&D (Employer Paid)

*You may choose one of the following options for yourself:*

Additional Life requested amount \$ \_\_\_\_\_ **OR**  Additional Life with AD&D requested amount \$ \_\_\_\_\_

**Dependents Life Insurance**

*You may choose one of the following options for your spouse:*

Spouse Life requested amount \$ \_\_\_\_\_ **OR**  Spouse Life with AD&D requested amount \$ \_\_\_\_\_

Spouse Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

*You may choose one of the following options for your child(ren):*

Child(ren) Life \$10,000 **OR**  Child(ren) Life with AD&D \$10,000

**Long Term Disability**

Employer Paid LTD

**Beneficiary** *This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.*

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

**Signature** I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required \_\_\_\_\_ Date (Mo/Day/Yr) \_\_\_\_\_

## Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, “Dorothy Q. Smith, Trustee under the trust agreement dated \_\_\_\_\_.”
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer’s coverage under the Group Policy.