Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT

Your Name (Last, First, Middle)	Group Name City of Billings	Group Number(s) 643501	
Your Address	City	State	ZIP
Your Soc. Sec. No.	Date Of Birth	☐ Male ☐ Female	Job Title/Occupation

Have you or your spouse used tobacco in any form in the last 12 months? Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

LIFE

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

Life Insurance

☒ Life with AD&D Employer Paid

Additional/Optional Life

☐ Additional/Optional Life Amount currently inforce $ ________ Requested amount $________

Dependents Life Insurance

☐ Spouse Life Amount currently inforce $ ________ Requested amount $________

Spouse Name________________________ Date of Birth________

DISABILITY

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

Long Term Disability

☐ Voluntary 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**

CHANGE

Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

☐ Add Dependent ☐ Delete Dependent ☐ Name Change ☐ Beneficiary Change

Date of add/delete ____________ Former name ____________ ☐ Other ____________

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. I represent that the statements contained herein are true and complete, to the best of my knowledge and belief. I acknowledge that I have read the Fraud Notice which pertains to my state of residency on the back of this form.

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

Human Resources Department - Complete this section. Retain form for your records.

Dvsn ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings $________ Per: ☐ Hour ☐ Wk ☐ Mo ☐ Yr