Dearborn National

ENROLLMENT and CHANGE FORM

Underwritten by Dearborn National® Life Insurance Company **Administrative Offices**: Downers Grove, Illinois | Dallas, Texas

☐ New Enrollment ☐ Change ☐ Open Enrollment ☐ COBRA ☐ Retiree

EMPLOYER/EMPLOYEE SECTION - Enrollment forms must be submitted to Human Resources at Beacon Health System – 574-647-6514

EMPLOYER	GROUP NO./ACCOUNT NUMBER	LOCATION / BILLING DIVISION
BEACON HEALTH SYSTEM	**F014542**	

EMPLOYEE NAME – LAST	FIRST	MIDDLE INITIAL	GENDER	DATE OF BIRTH	DATE OF HIRE (FULL TIME)

SOCIAL SECURITY NO.	EARNINGS $___________ ☐ Weekly ☐ Monthly ☐ Annual	JOB TITLE	CLASS

HOME ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE

BENEFIT SELECTION – Life & Disability

COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. **Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.**

Supplemental Coverage	Total Amount Coverage Desired	Prior Coverage Amount
Supplemental Life/ AD&D - Employee	**$**	**$**
Supplemental Life/ AD&D – Spouse	$	**$**
Supplemental Life/ AD&D Dependent Child(ren)	**$**	**$**

VOLUNTARY SHORT-TERM DISABILITY (STD)*** 60% of weekly earnings to a weekly maximum of $1,400

☐ Yes ☐ No Please Select One:

☐ Option 1 Plan: 8/8/25

☐ Option 2: Plan: 15/15/24

☐ Option 3: Plan: 8/8/12

☐ Option 4: Plan: 15/15/11

SPOUSE NAME-LAST	FIRST	M.I.	SEX M ☐ F☐	SPOUSE DATE OF BIRTH	SPOUSE SOCIAL SECURITY #

BENEFICIARY DESIGNATION (For Employee Only: Must Be Completed if you have applied for life or AD&D insurance) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100% (Employee is the beneficiary of proceeds from spouse or child coverage.)

FIRST NAME	LAST NAME	DATE OF BIRTH	RELATIONSHIP	SOCIAL SECURITY #	BENEFIT %
Primary					%
Primary					%
Contingent					%

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy(ies) issued to the employer listed above. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I do not remain actively at work that my coverage may lapse or terminate. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.

EMPLOYEE SIGNATURE ___________________________________ DATE _____________________

Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico. (Form #9-552-411 Z5222)