Dearborn National®

Underwritten by Dearborn National® Life Insurance Company

Enrollment and Change Form

Administrative Offices: Downers Grove, Illinois I Dallas, Texas

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

Employer/ Employee Section

Enrollment forms must be submitted directly to Dearborn National unless the group is self-administered. If the group is self-administered, submit enrollment forms to Dearborn National only if evidence of insurability is required.

EMPLOYER	GROUP NO. / ACCOUNT NUMBER	LOCATION
MIAMI TRACE LOCAL SCHOOLS	MG21236-7	

EMPLOYEE NAME - LAST FIRST MIDDLE INITIAL	SEX M☐ F☐	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

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.**

Basic Coverage

☑ Term Life / AD&D

Voluntary Coverage (Check all that apply) Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.		(A)Add, (C)Change (D)Delete	Total Amount of Coverage Desired	If (C)hange, list Prior Coverage
☐ Term Life	Employee			
☐ Term Life	Spouse			
☐ Term Life	Child(ren)			
☐ Voluntary AD&D	☐ Employee ☐ Family			

Spouse Name - Last First M.I. (If Applicant)	Sex ☐ M ☐ F	Spouse Date of Birth	Spouse Social Security #

Has the employee (if applying) used **any** tobacco products in the last 2 years?	☐ Yes ☐ No
Has the spouse (if applying) used **any** tobacco products in the last 2 years?	☐ Yes ☐ No

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	Social Security No.	Date of Birth	Relationship	Percentage
Primary				%
Primary				%
Contingent				%
Contingent				%

FOR DEARBORN NATIONAL USE ONLY

EMPLOYEE SIGNATURE _____ DATE ___/___/___

Waiver of Coverage:

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the company.

EMPLOYEE SIGNATURE _____ DATE ___/___/___

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