SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135

Mailing Address: Select Benefit Administrators
PO Box 440 | Ashland, WI 54806
Overnight deliveries to: 118 3rd Street East | Ashland, WI 54806
Phone 1-800-497-3699 | Fax (715) 682-5919

ENROLLMENT/CHANGE REQUEST

For Select Benefits Group Insurance

Group Information (To be Completed by Employer)

Group name	Effective date for action requested	Group number
University of North Alabama		12628000

☐ Newly-Eligible Request ☐ Subsequent Enrollment Period ☐ Special Enrollment Request

Reason_____

Your Information (To be completed by individual requesting coverage)

Name				Social Security number
Date of birth	Date of hire	Gender ☐ M ☐ F	Home phone	Work phone
Job title / occupation		I am actively working ☐ Yes ☐ No		Average number of hours worked per week
Home address		City	State	Zip
Email address		Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Separated ☐ Widowed ☐ Domestic Partner ☐ Civil Union ☐ Common Law		

Action Requested

☐ Enroll in the coverage for insurance as selected below.
☐ Change (add, increase, decrease, terminate) my current coverage, as shown below.
☐ Update information about me, my dependents and/or beneficiaries.
☐ Terminate all current coverage.

Coverage

Fixed-Payment Medical

Option ___ Low Plan, __ High Plan
Identify coverage option

☐ Self
☐ Self plus spouse
☐ Self plus child(ren)
☐ Self plus family

Accident

Option ___ Premier
Identify coverage option

☐ Self
☐ Self plus spouse
☐ Self plus child(ren)
☐ Self plus family
☐ Decline

Critical Illness*

Option ___ $10,000, ___ $20,000, ___ $30,000
(Indicate current amount)

☐ Self
☐ Self plus spouse
☐ Self plus child(ren)
☐ Self plus family
☐ Decline

Have you used nicotine in the past 12 months? ☐ Yes ☐ No

** Evidence of insurability may be required*

Dependent Information *(Complete to add, change or terminate coverage for dependents. List additional dependents on a separate sheet and attach to this form.)*

No person can be insured under any policy as both a certificateholder and a dependent, or as a dependent of more than one certificateholder. The effective date of coverage for a dependent who is confined may be delayed.

Name

Date of birth	Gender	Full-time student	Relationship
	☐ M ☐ F	☐ Yes ☐ No	

Home address (if different than your address) | City | State | Zip

☐ Add
☐ Change
☐ Terminate

Coverage: ☐ Fixed-Payment Medical ☐ Accident ☐ Critical Illness

Name

Date of birth	Gender	Full-time student	Relationship
	☐ M ☐ F	☐ Yes ☐ No	

Home address (if different than your address) | City | State | Zip

☐ Add
☐ Change
☐ Terminate

Coverage: ☐ Fixed-Payment Medical ☐ Accident ☐ Critical Illness

Name

Date of birth	Gender	Full-time student	Relationship
	☐ M ☐ F	☐ Yes ☐ No	

Home address (if different than your address) | City | State | Zip

☐ Add
☐ Change
☐ Terminate

Coverage: ☐ Fixed-Payment Medical ☐ Accident ☐ Critical Illness

Signatures *(Sign and date **only one option** below. Retain a copy for yourself. Provide the original to your insured group's representative.)*

Authorization *(If you are enrolling in, changing or updating coverage)*

☐ I, the undersigned, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy (or policies) insured by Symetra Life Insurance Company. I authorize the deduction from my earnings for any contribution I am required to make toward the cost of this insurance. I further understand that I may not be able to make any changes to my elected coverage until the next enrollment period.

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

This form replaces all Enrollment/Change Request forms previously submitted.

Enrollee/Employee signature	Date

Waiver *(If you are declining or terminating all coverage.)*

☐ I, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 30 days of the date I am first eligible, that I may have to wait to obtain coverage until the next enrollment period.

Further, I understand that I may not be able to obtain coverage for benefits in the future without submitting satisfactory evidence of insurability 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.

Reason: ☐ I already have insurance ☐ Other____________________

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

This form replaces all Enrollment/Change Request forms previously submitted.

Enrollee/Employee signature	Date