



United Heritage Life Insurance Company Group Insurance Beneficiary and Enrollment Form

P.O. Box 7777 - Meridian, ID 83680-7777

Please fill out Sections 1-6 for personal information on the employee.

1. Employee's Last Name	First	Middle Initial	Date of Birth (Month/Day/Yr.)	Group Number
2. Name of Employer		Employee Job Title	Full-Time Employment (Month/Day/Yr.)	Hours Worked Per Week
3. Male <input type="checkbox"/> Female <input type="checkbox"/>	4. Social Security Number		5. Gross Monthly Salary	

**Please fill out Section 6 ONLY if your plan has employee Life Insurance.
Your primary beneficiary will receive your death benefit in the event of your death.
The contingent beneficiary will receive your death benefit if the primary beneficiary is no longer living.**

6. Primary Beneficiary's Last Name	First	Middle Initial	Relationship to You
Full Address of Beneficiary			Phone
Contingent Beneficiary's Last Name	First	Middle Initial	Relationship to You
Full Address of Contingent Beneficiary			Phone

**Please fill out Section 7 if you, the "insured" are paying for all or a portion of your premium payment.
Also mark which benefits offered by your employer, you would like to be provided in your Group Policy.
Make sure you fully understand the benefits offered by your employer first.
NOTE: EVIDENCE OF INSURABILITY MAY BE REQUIRED.**

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
7. Employee Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Short Term Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>
Dependent Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Amount \$ _____		
Short Term Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Supplemental/Voluntary Group Life Insurance	<input type="checkbox"/>	<input type="checkbox"/>
Long Term Disability Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Employee Amount \$ _____	<input type="checkbox"/>	<input type="checkbox"/>
Additional Buy-Up LTD Plan	<input type="checkbox"/>	<input type="checkbox"/>	Spouse Amount \$ _____	<input type="checkbox"/>	<input type="checkbox"/>
			Children's Amount \$ _____	<input type="checkbox"/>	<input type="checkbox"/>

Please fill out Section 8 ONLY if your plan has Dependent Life (Spouse, and unmarried Children).

8. Marital Status	Date of Birth of Spouse (Month/Day/Yr.)	Number of eligible Dependents (Include Spouse)
Single <input type="checkbox"/> Widowed <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/>		

9. Unless otherwise provided herein, Beneficiaries designated to share proceeds shall share equally and the share of any Beneficiary who does not survive me shall be paid to the Contingent Beneficiary. If no Beneficiary survives me, the payment shall be made according to the terms of the policy, subject to revocation by me by written notice to my employer. I request the insurance provided by my employer's group insurance plan(s), and authorize the required deduction, (if any) from my wages.

United Heritage Life Insurance Company assumes no responsibility for the beneficiary designation complying with any community property laws relating to the designation. Community property states include: Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington and Wisconsin.

Date Signed _____ **Employee Signature** _____