



LifeMap Assurance Company  
 P.O. Box 1271, M/S E8L  
 Portland, OR 97207  
 (503) 721-7161 • (800) 794-5390

## LifeMap Voluntary Benefits Employee Enrollment and Change Form

**For residents of California, Oregon and Washington**, the definition of a Spouse includes your legal husband or wife or your State Certified/Registered Domestic Partner. Please contact your employer for any additional eligibility requirements.

**For residents of Alaska, Idaho, Utah, Montana and Wyoming**, the definition of a Spouse includes your legal husband or wife. Please contact your employer for any additional eligibility requirements.

**Please complete using dark ink.**

<b>Employer Name</b> Bonneville County		<b>Group Number</b> WBT000920	
<input type="checkbox"/> New Enrollment – Date of Hire/Rehire (mm/dd/yyyy) _____		<input type="checkbox"/> Change of Existing Enrollment	
Employee's Name (Last, First MI)	Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Occupation		Annual Salary	
Home Address (Street, City, State and Zip)		Telephone Number (     )	
Spouse Name (If applying for coverage)	Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	Social Security Number
Within the past 2 years has you or your spouse used cigarettes or other tobacco products? Employee <input type="checkbox"/> Y <input type="checkbox"/> N Spouse <input type="checkbox"/> Y <input type="checkbox"/> N			

**If for any coverage (except AD&D) you select an amount OVER the Guarantee Issue Amount or are making application for any coverage AFTER your initial 31-day eligibility period, you must also complete and submit a LifeMap Evidence of Insurability Form.**

**Please indicate the total amount of voluntary coverage you wish to have for initial enrollment or when making changes to coverage.**

### Voluntary Life Insurance

**Select Amount** in \$10,000 increments to a maximum of \$300,000, not to exceed 5 times your annual earnings for the employee.

Employee \$ \_\_\_\_\_  No Coverage      Spouse \$ \_\_\_\_\_  No Coverage

The beneficiary designation made for Basic Life Insurance, if provided, will apply unless you complete a separate beneficiary designation for Voluntary Life. Employee is the beneficiary of any Spouse or Child coverage.

### Voluntary Life Insurance for Children

**Select Amount**    Employee     \$2,000     \$4,000     \$6,000     \$8,000     \$10,000     No Coverage  
                          Spouse         \$2,000     \$4,000     \$6,000     \$8,000     \$10,000     No Coverage

You or your Spouse must be approved for Voluntary Life Insurance coverage in order for your Dependent Children to be enrolled.

### Voluntary Accidental Death and Dismemberment (AD&D) Insurance

**Select Amount** in \$10,000 increments to a maximum of \$300,000, not to exceed 5 times your annual earnings for the employee.

Employee \$ \_\_\_\_\_  No Coverage      Spouse \$ \_\_\_\_\_  No Coverage

### Voluntary AD&D Insurance for Children

**Select Amount**    Employee     \$2,000     \$4,000     \$6,000     \$8,000     \$10,000     No Coverage  
                          Spouse         \$2,000     \$4,000     \$6,000     \$8,000     \$10,000     No Coverage

You or your Spouse must be approved for Voluntary AD&D Insurance coverage in order for your Dependent Children to be enrolled.

**Please continue application on the following page.**

**Note: The Accidental Death and Dismemberment (AD&D) Certificates provide limited benefits. Review your certificate carefully.**

**IMPORTANT: Your application for coverage is not complete if this page is not signed, dated and returned.**

I request to be insured and authorize payroll deductions to cover the cost of coverage. Information in this application is given to obtain insurance, and the statements and answers are represented, to the best of my (our) knowledge and belief, to be true and complete. I (we) understand that (a) the insurance applied for shall not take effect until the application is approved and I will be notified of the insurance Effective Date; and (b) all insurance is subject to the eligibility provisions of the Policy; and (c) I must be Actively at Work (as defined in the Group Policy) to be insured. If I am not Actively at Work on the date my (our) coverage would become effective, my (our) coverage will not begin until the day I return to work.

**Insurance Fraud Warning:**

**Unless specific state language is provided below, the following general fraud notice applies:** Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

**For residents of Washington:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

If your answers on this application are incorrect or untrue, LifeMap Assurance Company has the right to deny benefits or rescind your coverage for up to two years from the date coverage becomes effective.

▶ \_\_\_\_\_  
Employee Signature

▶ \_\_\_\_\_  
Date Signed

▶ \_\_\_\_\_  
Spouse Signature (if applying for coverage)

▶ \_\_\_\_\_  
Date Signed