LifeMap Assurance Company™
P.O. Box 1271, MS E-3A
Portland, OR 97207-1271
(503) 721-7161 • (800) 794-5390

Employee Enrollment and Change Form with Beneficiary Designation

For residents of 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 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 print in blue or black ink; complete all information requested.

Employer Name	**Group Number**		Occupation
☐ New Enrollment – Date of Hire/Rehire (mm/dd/yyyy) _____			☐ Change of Existing Enrollment
Employee's Name (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Do you have dependents? (Spouse or Children) ☐ Yes ☐ No If yes, do you wish to enroll them in Dependent Life Insurance coverage? ☐ Yes ☐ No (If Available To Your Group)			

Check one and sign below: (If Employer pays 100% of the premium for this coverage, please skip this section.)

☐ **I HEREBY APPLY FOR ENROLLMENT** with LifeMap Assurance Company under the Group Insurance Plan of the Employer named above. I understand this will not be in force until my return to full time employment should I not be actively at work (i.e., leave of absence, sick leave) on my effective date. I authorize the Employer named above to withhold insurance premiums, if required, from my paycheck and to pay them directly to LifeMap Assurance Company.

☐ **I DO NOT WISH TO APPLY** with LifeMap Assurance Company for the Group Insurance Plan available to me. The benefits of the Plan have been thoroughly explained to me, and I decline to participate. I fully understand that I cannot enroll in the future except by providing evidence of insurability to LifeMap Assurance Company and that I am forfeiting any employer contribution for this program.

ALL PERSONS ENROLLING IN LIFE COVERAGE SHOULD COMPLETE THIS SECTION

Please See Page 2 For Instructions For Completing Your Beneficiary Designation. If you wish to name additional beneficiaries, please attach a separate piece of paper with all of the necessary information, including the date and your signature.

Primary Beneficiary (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You		**Benefit %**
Primary Beneficiary (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You		**Benefit %**

If Primary Beneficiary(ies) dies before you, the benefit will be paid to your Contingent Beneficiary(ies).

Contingent Beneficiary (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You		**Benefit %**

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.

Sign, date and return this form to your Benefits Administrator.

Signature Of Employee					**Date Signed**
Employer: Please complete this section if using this form for benefit enrollment. Group No. Effective Date Class Dept Salary $					☐ **Hourly** ☐ **Annual** ☐ **Monthly** ☐ **Other**

Instructions For Completing Your Beneficiary Designation

The Primary Beneficiary receives the Life and AD&D proceeds upon your death. You may have more than one Primary Beneficiary. If so, please provide their full names, dates of birth, Social Security numbers, addresses, and the percentage of proceeds you would like each Primary Beneficiary to receive. The Contingent Beneficiary receives proceeds only if the Primary Beneficiary(ies) dies before you. Please provide their full name, date of birth, Social Security number and address. Examples follow:

A.	One Primary Beneficiary	Mary R. Jones – 100% (list information)
B.	Two or more Primary Beneficiaries	50% to John Jones and 50% to Sally Smith (list information for both.)
C.	Two or more Primary Beneficiaries in Unequal Shares	75% to John Jones and 25% to Sally Smith (list information for both)
D.	One Primary and Contingent Beneficiary	100% to Mary R. Jones, if living, otherwise to Sally Smith (list information for both)
E.	Trustee	Mary R. Jones, Trustee, under trust agreement dated _____
F.	Insured's Estate	My Estate

Under items B. and C. above, if one of the Primary Beneficiaries dies before you, 100% of the proceeds will go to the living Primary Beneficiary(ies).

Do you know that if death occurs and a minor (a person not of legal age) is the beneficiary, it may be necessary to have a Guardian of the Estate of the minor, or a Conservator for the minor appointed before any death benefit can be paid? This means legal expenses for the beneficiary and delay in the payment of the insurance. Please take this into consideration when naming your beneficiary.