Life Insurance Enrollment

WEA Insurance Corporation
P.O. Box 21538, Eagan, MN 55121-5038
800.279.4000 · WeaTrust.com

Please complete every section and every field on this form. Applications not completed in full cannot be processed.

Section 1–Employee Information

Employee Name (Last, First, Middle Initial)

Gender
☐ **Male** ☐ **Female**

Marital Status
☐ **Single** ☐ **Married** ☐ **Domestic Partnership**

Street Address (or P. O. Box) **City** **State** **Zip**

Date of Birth (MM/DD/YYYY) **Telephone Number**

Social Security Number **Subscriber Number** (not applicable for first time enrollment)

Are you
☐ Totally disabled? ☐ On sick leave? ☐ On medical leave? ☐ Retired? ☐ On COBRA? If YES, please provide start date:
/ /

Section 2–Employment Information

Employer Name

WEA Trust Group Number **First Day of Employment** (MM/DD/YYYY) **Annual Salary** **Average Hours Worked/Week**

Occupation

Section 3–Reason for Application

Choose one of the following events:

☐ New employee
☐ Rehire
☐ Return from layoff
☐ Return from leave
☐ Birth, adoption/placement for adoption
☐ Marriage, adding spouse and/or dependents
☐ Change in work hours. Indicate the number of hours per week you *were* working:_____hours
☐ Divorce
☐ Change of Occupation
Previous Occupation _____
☐ Change of beneficiary information
(Please complete Beneficiary Section on page 4)
☐ Other: _____

Date that the event indicated above occurred (MM/DD/YYYY)

(continue to next page)

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Life Insurance Enrollment Form

Subscriber Number or Employee Social Security Number: _____

Section 4–Type of Insurance Coverage *(to determine if you are eligible for Additional Purchase Life Coverage or Dependent Life Coverage, please check with your employer)*

☐ **Employee Life Coverage**

Additional Purchase Options

☐ Additional Purchase

Please indicate the amount:

☐ $25,000 ☐ $75,000

☐ $50,000 ☐ $100,000

☐ $_____

Dependent Life Insurance Options (Select One)

☐ Dependent Life Insurance ($7,500 spouse & $3,750 children)

☐ Double Dependent Life Insurance ($15,000 spouse & $7,500 children)

Section 5–Waiver of Coverage

I understand that I am eligible to apply for life insurance coverage through my employer. I do not want, and hereby waive, any life insurance coverage.

☐ Please check this box if you are waiving coverage.

Waiving life coverage may not be permissible in some cases. Please check with your employer if you are uncertain whether you are required to enroll.

Signature: _____ Date:_____

(continue to next page)

Life Insurance Enrollment Form

Subscriber Number or Employee Social Security Number: ______________________________

Section 6–Dependent Information *(Please complete in full if you are applying for dependent life coverage)*

☐ **Spouse** ☐ **Domestic Partner Name** (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender
☐ Male ☐ Female

Is this spouse/domestic partner disabled?
☐ No ☐ Yes

Dependent Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender
☐ Male ☐ Female
Is this dependent disabled? ☐ **No** ☐ **Yes**

Relationship
☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: ____________

Dependent Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender
☐ Male ☐ Female
Is this dependent disabled? ☐ **No** ☐ **Yes**

Relationship
☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: ____________

Dependent Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender
☐ Male ☐ Female
Is this dependent disabled? ☐ **No** ☐ **Yes**

Relationship
☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: ____________

Dependent Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender
☐ Male ☐ Female
Is this dependent disabled? ☐ **No** ☐ **Yes**

Relationship
☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: ____________

Dependent Name (Last, First, Middle Initial) **Date of Birth** (MM/DD/YYYY) **Social Security Number**

Gender
☐ Male ☐ Female
Is this dependent disabled? ☐ **No** ☐ **Yes**

Relationship
☐ Child ☐ Stepchild ☐ Legal Ward ☐ Other: ____________

Section 7–Signature and Authorization

I understand that if I do not apply for life insurance coverage when initially eligible and instead apply later, my dependents and I will be required to meet very strict standards of insurability and there is no guarantee I/we will be accepted for coverage. I understand that the amount of life coverage applied for may require me or my dependents to meet standards of insurability before such coverage is effective. If any of the plans require a salary deduction, I hereby authorize my employer to make all necessary deductions.

Signature **Date** (MM/DD/YYYY)

(Please continue to next page to complete the Life Beneficiary Designation Form)

Enrollment Form Life Insurance Beneficiary Designation

Insured Employee Information

Employee Name (Last, First, Middle Initial)

Social Security Number **Subscriber Number** (not applicable for first time enrollment)

Reason for Completing Form (select one)

☐ Initial Designation of Beneficiary ☐ Change of Designation of Beneficiary

Beneficiary Information

Please list your beneficiary's name and relationship to you in the spaces provided. If you list a beneficiary that is not a person (e.g., a charitable organization or trust), please list the relationship as "other." If you designate more than one beneficiary, we will pay the benefits equally to each of your designated beneficiaries. If you want us to pay the benefits in differing percentages, please indicate the percentage for each beneficiary in the space provided. The total for all beneficiaries must equal 100%. If you do not have a named beneficiary, or no beneficiary survives you, payment will be made according to policy provisions.

The beneficiary for insurance on the lives of your dependents will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions. A beneficiary for employee life or accidental death insurance may be changed upon written request.

Beneficiary type (Select one) ☐ Primary ☐ Contingent

Name (Last, First, Middle Initial) **Relationship to You**

Date of Birth (MM/DD/YYYY) **Social Security Number** **Percentage of Proceeds** %

Beneficiary type (Select one) ☐ Primary ☐ Contingent

Name (Last, First, Middle Initial) **Relationship to You**

Date of Birth (MM/DD/YYYY) **Social Security Number** **Percentage of Proceeds** %

Beneficiary type (Select one) ☐ Primary ☐ Contingent

Name (Last, First, Middle Initial) **Relationship to You**

Date of Birth (MM/DD/YYYY) **Social Security Number** **Percentage of Proceeds** %

Beneficiary type (Select one) ☐ Primary ☐ Contingent

Name (Last, First, Middle Initial) **Relationship to You**

Date of Birth (MM/DD/YYYY) **Social Security Number** **Percentage of Proceeds** %

Spousal Consent *(complete only if spouse is not designated as the sole primary Beneficiary)*

As spouse of the employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse **Date** (MM/DD/YYYY)

Signature and Authorization

IMPORTANT: This beneficiary designation revokes all prior beneficiary designations. If you are changing your beneficiary, we will confirm the change in writing. Beneficiary designations are not valid without a signature and date.

Signature **Date** (MM/DD/YYYY)

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