CNMI GOVERNMENT GROUP LIFE INSURANCE ENROLLMENT FORM

☐ Re-Enrollment ☐ New Enrollee ☐ Change ☐ Termination

Last Name	First Name		Middle Name
Mailing Address			Date of Birth
			Marital Status ☐ Married/Common-Law ☐ Single
Government Department	Employment Date	Social Security Number	Phone Number

Employment Status

☐ Active; 20 or more hours per week ☐ Retiree Name of employer retired from:

_____

Are you presently on leave of absence from work due to sickness, injury, medical treatment, or unpaid leave of absence for personal reasons?

☐ Yes ☐ No If yes, identify the leave and state the reason(s):

INDIVIUDAL'S TERM LIFE INSURANCE Available to Active Employees and Retirees

☐ I want Individual's Term Life Insurance

OPTIONAL DEPENDENT'S TERM LIFE INSURANCE Available to Active Employees Only

☐ I elect Dependent's Term Life Insurance Option: ☐ 1 ☐ 2 ☐ 3 ☐ 4

Option 4 only: Complete the following for each parent/parent in-law to be covered. Evidence of insurability is required.

Name (last, first, middle)	Relationship	Name (last, first, middle)	Relationship

Complete the following for all other non-parent Dependents to be covered.

Name (last, first, middle)	Date of Birth	Social Security Number	Relationship

The Employee is the beneficiary of Dependent Life Insurance benefits.

☐ I **WAIVE** the optional Dependent's Term Life Insurance coverage. I understand that I will have **NO** Dependent's Term Life Insurance coverage, and if I apply at a later date, I will be required to furnish evidence of insurability.

BENEFICIARIES The total of the Percentage column must equal 100%, or check here ☐ for equal shares.

Legal Name (last, first, middle)	Relationship	Age or Date of Birth	Percentage
			%
			%
			%
			%
			%
			%

☐Minor Beneficiary Form completed

INSURANCE AUTHORIZATION

By signing below, I declare that the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I apply for coverage more than 61 days from my Employment Date, I will be required to furnish evidence of insurability for all individuals for whom coverage is requested. I also understand that regardless of when enrollment occurs, the addition of new parent(s) always requires completion of evidence of insurability. Coverage is not effective until approved by Individual Assurance Company. I authorize my employer to deduct from my earnings the required cost of the coverage(s) I have elected above.

Signature: Date:

FOR EMPLOYER USE ONLY

Annual Salary: $_____ Basic Life Coverage: $_____ Premium Deduction: $_____ Process Date: _____

Underwritten by Individual Assurance Company, Life, Health & Accident, 3200 E. Memorial Road, Suite 100, Edmond, OK 73013

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