RESET FORM

Basic Life Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee.

Name of Employer/Plan Sponsor North American Division of Seventh-day Adventists		Group/Plan Number 67807-4	Account Number/Location
Class/Occupation	Date of Hire *(mm/dd/yyyy)*	Annual Salary	Employment Status: ☑ Active Full-Time
Effective Date of Coverage or Change:			

A late entrant is an individual who is first enrolling for coverage after the first available opportunity.

Employee Information

Employee Name *(last, first, middle initial)*	Date of Birth *(mm/dd/yyyy)*	Social Security #	Employee I.D. #
Employee Address *(street address, city, state, zip code)*	Work Phone Number	Home Phone Number	☐ Female ☐ Male

Employee Life Insurance

Basic Life (Note: Basic Life insurance is employer provided.)	Only Full-Time Employees are eligible for coverage. ☐ Plan A (Employee - $50,000, Spouse - $50,000, Child(ren) - $2,000) ☐ Plan B (Employee - $50,000, Spouse - $2,000, Child(ren) - $2,000)

Beneficiary Information *Designate your beneficiary(ies) below.*

Name of Beneficiary *(last name, first, middle initial)* ☑ Primary		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Name of Beneficiary *(last name, first, middle initial)* ☐ Primary ☐ Contingent		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Name of Beneficiary *(last name, first, middle initial)* ☐ Primary ☐ Contingent		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee's Signature	Date Signed *(mm/dd/yyyy)*