

To Be Completed By Human Resources

Group Number <b>154052</b>	Division <b>0001</b>	Billing Category <b>Non-Administrators</b>	Date of Employment
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To Be Completed By Applicant  Apply for Coverage  Beneficiary Change *Complete Beneficiary Section below.*  Name Change  
 Add or  Delete Dependent Date of add/delete \_\_\_\_\_

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Your Address		City	State	ZIP
Former Name (Last, First, Middle) <i>Complete only if name change</i>			Phone Number	
Employer Name <b>Addison Northwest Supervisory Union</b>			Job Title/Occupation	
Hours Worked Per Week	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year			

**Coverage Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.**

**Life Insurance**  
 Life with AD&D (Employer Paid)

**Long Term Disability**  
 Employer Paid LTD

**Beneficiary** *This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.*

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

**Signature** I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required \_\_\_\_\_ Date (Mo/Day/Yr) \_\_\_\_\_