

# 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 <input type="checkbox"/> Married/Common-Law <input type="checkbox"/> Single
Government Department	Employment Date	Social Security Number
		Phone Number
Employment Status <input type="checkbox"/> Active; 20 or more hours per week <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No   If yes, identify the leave and state the reason(s):		

**INDIVIDUAL'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, 930 E. 2nd Street Edmond, OK 73034