Diocese of Winona
GROUP LIFE INSURANCE ENROLLMENT FORM
Policy # 551767-18

Location # _____

Employee Name (last name, first, middle initial)		Policyholder Name Diocese of Winona	
Employee Address (street, city, state, zip code)		Social Security Number	Date of Birth
Sex ☐ Male ☐ Female	Salary $ _____ ☐ Weekly ☐ Monthly ☒ Annually	Hours Worked per Week	Occupation/Title
Full Time Date of Hire or Date you enter an eligible class			

Coverage Elections: Your employer will inform you of available coverage. Check yes to enroll; check no if you decline or coverage is not available.

Life ☒ **Yes** ☐ **No**
AD&D ☐ **Yes** ☒ **No**
Dependent Life ☐ **Yes** ☒ **No**

Life Amount $ _____
AD&D Amount $ _____

LTD ☒ **Yes** ☐ **No**
STD ☐ **Yes** ☒ **No**

Note: If you have chosen Life coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective on the first of the month coincident with or next following the date UnumProvident approves your Evidence of Insurability form. If you **do not apply for** any of the above coverage during your initial enrollment period and choose to enroll at a later date, you will need to complete an Evidence of Insurability form for all amounts of coverage.

Beneficiary Information* (complete only if Life Coverage is selected)

Name (last name, first, middle initial):	Relation to You:	Benefit %:
If the Beneficiary(ies) named above are not living, then pay:		

*Note: Benefits cannot be sent directly to a minor. Please consult your policy for additional information.

Request for Signature and Certification:

I understand that my insurance coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available to me at my request. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature	Date	Work Phone	Home Phone

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