

NOTE: PLEASE RETURN THIS FORM TO THE PERSON THAT HANDLES THE BENEFITS AT YOUR PARISH/SCHOOL/INSTITUTION, AND IT WILL BE FORWARDED TO THE DIOCESE OF GARY.



Mailing Address:
Symetra Life Insurance Company
Group Division
PO Box 34690
Seattle, WA 98124-1690

**LIFE INSURANCE
ENROLLMENT FORM**

TO BE COMPLETED BY THE EMPLOYER			
POLICY # <u>01015013</u>			
EMPLOYER/POLICYHOLDER NAME: <u>DIOCESE OF GARY</u>			
<u>9292 BROADWAY</u>	<u>MERRILLVILLE</u>	<u>IN</u>	<u>46410</u>
STREET ADDRESS	CITY	STATE	ZIP CODE
EMPLOYEE OCCUPATION/JOB TITLE		EMPLOYEE DATE OF EMPLOYMENT	
		<u>Full-Time Employee</u>	
EFFECTIVE DATE OF COVERAGE		FULL OR PART TIME EMPLOYEE	
\$ <u>NA</u> / <input type="checkbox"/> HR <input type="checkbox"/> WK <input type="checkbox"/> MO <input type="checkbox"/> YR BASIC EARNING*		NA CLASS NUMBER (IF APPLICABLE)	

I. EMPLOYEE INFORMATION

SEX M F

NAME _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME TELEPHONE NUMBER _____ DATE OF BIRTH _____ MARITAL STATUS _____

II. BENEFITS: PLEASE CHECK IF YOU WISH TO ENROLL AND INCLUDE BENEFIT AMOUNT

Employee Life:	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	X BAE*	OR	\$ 10,000.00
Employee AD&D:	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	X BAE*	OR	\$ NA
Employee Supplemental Life: NA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	X BAE*	OR	\$ NA
Employee Supplemental AD&D: NA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	X BAE*	OR	\$ NA
Dependent Life:					
Spouse: NA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	X BAE*	OR	\$ NA
Child: NA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	X BAE*	OR	\$ NA
Spouse & Child: NA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	X BAE*	OR	\$ NA
Dependent AD&D:					
Spouse: NA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	X BAE*	OR	\$ NA
Dependent Supplemental Life:					
Spouse: NA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	X BAE*	OR	\$ NA
Child: NA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	X BAE*	OR	\$ NA
Spouse & Child: NA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	X BAE*	OR	\$ NA
Dependent Supplemental AD&D:					
Spouse: NA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	X BAE*	OR	\$ NA
Other: NA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	X BAE*	OR	\$ NA
Other: NA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	X BAE*	OR	\$ NA
Other: NA	<input type="checkbox"/> YES	<input type="checkbox"/> NO	X BAE*	OR	\$ NA

* BAE: Basic Annual Earnings as defined in your contract

III. BENEFICIARY DESIGNATION

Definitions:

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Date of Birth

NAME	ADDRESS	D.O.B	RELATIONSHIP	PRIMARY	CONTINGENT	% OF BENEFIT

IV. SELECTION/WAIVER OF GROUP INSURANCE

I, the undersigned, an employee of the above-named policyholder, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance (Not applicable if the [Employer] pays 100% of the required contribution).

I hereby waive my right at this time to elect the insurance coverages which I did not select above. I understand that if I do not enroll within 31 days, when first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death.

All information submitted by me on this form to the best of my knowledge and belief is true and complete.

EMPLOYEE SIGNATURE

DATE SIGNED