

**REGENCE LIFE AND HEALTH INSURANCE COMPANY  
ENROLLMENT FORM FOR GROUP INSURANCE**

1. Please print in blue or black ink; complete all information requested.
2. Instructions for naming your beneficiary are shown on the back of this form.
3. Sign and return this form to your Personnel Office.

LAST NAME	FIRST	INITIAL	BIRTHDATE MO   DA   YR	SEX M   F	SOCIAL SECURITY NO.	
NAME OF EMPLOYER		OCCUPATION			HIRE DATE	GROUP NO.
BENEFICIARY LAST NAME	FIRST (Given Name)	INITIAL	BIRTHDATE MO   DA   YR	SEX M   F	SOCIAL SECURITY NO.	
BENEFICIARY ADDRESS		CITY	STATE	ZIP CODE	RELATIONSHIP TO YOU	
Do you have dependents? (Spouse or Children) <input type="checkbox"/> Yes <input type="checkbox"/> No			If "Yes", do you wish to enroll them in Dependent Life Insurance coverage? (IF AVAILABLE IN YOUR GROUP) <input type="checkbox"/> Yes <input type="checkbox"/> No			

(Check one and sign below): If Employer pays 100% of the premium for this coverage, please skip this section.

<input type="checkbox"/> I HEREBY APPLY FOR ENROLLMENT with Regence Life and Health Insurance Company under the Group Insurance Plan of the Employer named above. I understand this coverage will not be in force until my return to full-time employment should I not be actively at work (i.e., leave of absence, sick leave) on my effective date. I hereby authorize the Employer named above to withhold insurance premiums, if required, from my paycheck and to pay them directly to Regence Life and Health Insurance Company.	<input type="checkbox"/> I DO NOT WISH TO APPLY with Regence Life and Health Insurance Company for the Group Insurance Plan available to me. The benefits of the Plan have been thoroughly explained to me, and I decline to participate. I fully understand that I cannot enroll in the future except by providing evidence of insurability to Regence Life and Health Insurance Company and that I am forfeiting any employer contribution for this program.
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SIGNATURE OF EMPLOYEE	DATE SIGNED
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EMPLOYER: Please complete this section.						<input type="checkbox"/> Hourly	<input type="checkbox"/> Annual
Group No.	Effective Date	Class	Dept	Salary \$		<input type="checkbox"/> Monthly	<input type="checkbox"/> Other

FORM RLH 013 - Front (Rev. 12/00)

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**For Life and AD&D Coverages, please provide full name, date of birth, Social Security number and address of your beneficiary. Examples follow:**

- |    |  |  |
|----|--|--|
| A. | One Beneficiary                              | Mary R. Jones, 1234 Hemlock St., Anytown, USA 12345  |
| B. | Two Beneficiaries                            | John Jones and Sally Smith, equally, or the survivor<br>(list information for both)                                    |
| C. | Two Beneficiaries in Unequal Shares          | John Jones, 75% and Sally Smith, 25%, or the survivor<br>(list information for both)                                   |
| D. | One Primary and One Contingent Beneficiary   | Mary R. Jones, if living, otherwise Sally Smith<br>(list information for both)   |
| E. | One Primary and Two Contingent Beneficiaries | Mary R. Jones, if living, otherwise Sally Smith and John Jones,<br>equally, or the survivor (list information for all) |
| F. | Trustee                                      | Mary R. Jones, Trustee, under trust agreement dated  |
| G. | Insured's Estate                             | My Estate  |

**Do you know that if death occurs and a minor (a person not of legal age) is the beneficiary, it may be necessary to have a Guardian of the Estate of the minor, or a Conservator for the minor appointed before any death benefit can be paid? This means legal expenses for the beneficiary and delay in the payment of the insurance. Please take this into consideration when naming your beneficiary.**

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