LifeMap Assurance Company
100 SW Market Street
P.O. Box 1271, MS E8L
Portland, OR 97207-1271
(503) 721-7161 • (800) 794-5390

Employee Enrollment and Change Form with Beneficiary Designation

For residents of Oregon and Washington, the definition of a Spouse includes your legal husband or wife or your State Certified/Registered Domestic Partner. Please contact your employer for any additional eligibility requirements.

For residents of Alaska, Idaho, Utah, Montana and Wyoming, the definition of a Spouse includes your legal husband or wife. Please contact your employer for any additional eligibility requirements.

Please print in blue or black ink; complete all information requested.

Employer Name	**Group Number** GR0040082		Occupation
☐ New Enrollment – Date of Hire/Rehire (mm/dd/yyyy) _____			☐ Change of Existing Enrollment
Employee's Name (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Do you have dependents? (Spouse or Children) ☐ Yes ☐ No If yes, do you wish to enroll them in Dependent Life Insurance coverage? ☐ Yes ☐ No (If Available To Your Group)			

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

☐ **I HEREBY APPLY FOR ENROLLMENT** with LifeMap Assurance Company under the Group Insurance Plan of the Employer named above. I understand this 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 authorize the Employer named above to withhold insurance premiums, if required, from my paycheck and to pay them directly to LifeMap Assurance Company.

☐ **I DO NOT WISH TO APPLY** with LifeMap Assurance 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 LifeMap Assurance Company and that I am forfeiting any employer contribution for this program.

ALL PERSONS ENROLLING IN LIFE COVERAGE SHOULD COMPLETE THIS SECTION

Please See Page 2 For Instructions For Completing Your Beneficiary Designation. If you wish to name additional beneficiaries, please attach a separate piece of paper with all of the necessary information, including the date and your signature.

Primary Beneficiary (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You		**Benefit %**
Primary Beneficiary (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You		**Benefit %**

If Primary Beneficiary(ies) dies before you, the benefit will be paid to your Contingent Beneficiary(ies).

Contingent Beneficiary (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Beneficiary Address (Street, City, State and Zip)	Relationship To You		**Benefit %**

Sign, date and return this form to your Benefits Administrator.

I certify that the answers I have made to the above questions are complete and true to the best of my knowledge and belief.
I acknowledge that I have read the fraud notice on page 3 of this form.

_____ _____
Employee Signature **Date**

Employer: Please complete this section if using this form for benefit enrollment.					☐ **Hourly** ☐ **Annual**
Group No.	Effective Date	Class	Dept	Salary $	☐ **Monthly** ☐ **Other**

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Instructions for Completing Your Beneficiary Designation

The Primary Beneficiary receives the Life and AD&D proceeds upon your death. You may have more than one Primary Beneficiary. If so, please provide their full names, dates of birth, Social Security numbers, addresses, and the percentage of proceeds you would like each Primary Beneficiary to receive. The Contingent Beneficiary receives proceeds only if the Primary Beneficiary(ies) dies before you. Please provide their full name, date of birth, Social Security number and address. Examples follow:

A.	One Primary Beneficiary	Mary R. Jones – 100% (list information)
B.	Two or more Primary Beneficiaries	50% to John Jones and 50% to Sally Smith (list information for both.)
C.	Two or more Primary Beneficiaries in Unequal Shares	75% to John Jones and 25% to Sally Smith (list information for both)
D.	One Primary and Contingent Beneficiary	100% to Mary R. Jones, if living, otherwise to Sally Smith (list information for both)
E.	Trustee	Mary R. Jones, Trustee, under trust agreement dated _____
F.	Insured's Estate	My Estate

Under items B. and C. above, if one of the Primary Beneficiaries dies before you, 100% of the proceeds will go to the living Primary Beneficiary(ies).

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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Insurance Fraud Notice

Unless specific state language is provided below, the following fraud notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Arizona Residents: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Maryland Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Arkansas, Louisiana, New Mexico, Rhode Island and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maine, Tennessee, Virginia and Washington Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Alaska and Oregon Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

Delaware, Idaho, Indiana and Oklahoma Residents: *Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.*