NAMIC®
NATIONAL ASSOCIATION OF MUTUAL INSURANCE COMPANIES
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NAMIC Group Insurance Trust

Enrollment/Change Notice

(Employer-Please complete sections 1, 2, 5, 6, 7 & 10)

Section 1 Employer Information

Company Number ____________ **(Existing plans may refer to a billing statement for this number, otherwise leave blank)**

Employer Name ____________

Employer Address ____________

Section 2 Reason for Completing This Form (check all that apply)

New Enrollee ☐	**Name Change** ☐	**Add Coverage** ☐
Late Enrollee ☐	**Address Change** ☐	**Delete Coverage** ☐
Special Enrollee ☐	**Beneficiary Change** ☐	**Waiver Coverate*** ☐

Section 3 Employee / Director Information

Social Security Number ____________ **Occupation** ____________

Name ____________
Last Name **First Name** **Middle Initial** **Gender** **DOB**

Address ____________
Number & Street **City** **State** **Zip Code**

Date Hired/Became Full Time/Appointed to Board ____________ **Hours Worked Weekly** ____________

Base Annual Salary ____________ **(Not Hourly Rate)** **(Not including Bonuses, Commissions, Etc.)**

Other Compensation (Most Recent Annual Bonuses and Commissions) ____________

Section 4 Dependent Information to Add or Delete Dependents (attach separate sheet if needed)

Name	Gender	Date of Birth	Social Security Number	Relationship to Employee	Full Time Student "Y" or "N"	Address (If different than above)

Section 5 Coverage Options

Please check the coverage(s) being applied for below. Availability of coverage is based on employer's selected plan of insurance.
Please enter Vol. Life/Vol. AD&D amounts in increments of $10,000 (EE), $5,000 (SP), and $2,000 (CH).

	Group Life	Long Term Disability	Short Term Disability	Group Dependent Life	High Option Dental	Low Option Dental	Vision	Voluntary Additional Life	Voluntary AD&D
Employee				N/A					
Spouse	N/A	N/A	N/A						
Child(ren)	N/A	N/A	N/A						

Please note: If an employee wishes to waive any available coverage, they must enter a "W" in the appropriate space above and initial Section 9.

Section 6 Requested Changes

☐ Name Change From ____________________ To ____________________

☐ Address Change To ____________________

☐ Complete Termination - All Coverage Date Last Worked ____________ Reason for Change ____________
(Retired, Hours reduced, etc.)

☐ Partial Termination - Only Coverage For ☐ Employee ☐ Spouse ☐ Children Date of Termination ____________

Please check all coverages to be changed for Partial Termination

	Group Life	Long Term Disability	Short Term Disability	Group Dependent Life	Dental High Option	Dental Low Option	Vision	Voluntary Additional Life	Voluntary AD&D
Employee				N/A					
Spouse	N/A	N/A	N/A						
Child(ren)	N/A	N/A	N/A						

Section 7 If Deleting Dependent(s), Please Indicate Individuals Still Covered After Deletion

☐ Employee ☐ Employee & Spouse

☐ Employee & Child(ren) ☐ Employee, Spouse & Child(ren)

Effective Date: ____________

NOTE: If coverage is deleted, requests to re-enroll are subject to plan provisions.

Section 8 Beneficiary Designation (Attach Separate Sheet if Necessary)

PRIMARY BENEFICIARY DESIGNATION

Full Name	Address	Relationship	Benefit (%)

CONTINGENT BENEFICIARY DESIGNATION (Attach Separate Sheet if Necessary)

Full Name	Address	Relationship	Benefit (%)

Section 9 Waiver of Coverage (Please Initial If Waiving Coverage)

* I hereby certify that I have been given an opportunity to apply for insurance under the group insurance policy(ies) offered by my employer through the NAMIC Group Insurance Trust and after careful consideration, I have decided not to take advantage of the products which I have marked with a "**W**" in Section 5. _________ (Initial Here)

Section 10 Employee: Please Read, Sign and Date Below

I certify that all statements are true to the best of my knowledge and belief. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. (Please refer to your certificate of coverage for the exclusions that apply to your coverage.)

I understand that in the event that I desire to request Long Term Disability, Short Term Disability, Dependent Life, Voluntary Additional Life and Voluntary AD&D at a later date, I may be required to furnish, at my own expense, evidence of insurability satisfactory to the Insurance Company, and the Insurance Company will have the right to refuse my request.

Employee / Director Signature ____________________ **Date:** ____________
(Required) -Please sign and initial above, if waiving coverage-

Company Benefit Administrator Approval ____________________ **Date:** ____________
(Required)

Please complete and return by mail or fax:
NAMIC Group Insurance Trust
PO Box 68700
Indianapolis, IN 46268-0700
Fax: 317-879-8408 Phone: 800-336-2642

****The life insurance benefit does not include bonuses, commissions, and tips and tokens, overtime pay or any other fringe benefits or extra compensation. Life benefits will be paid according to the provisions of the policy.**