

**ENROLLMENT  
FORM**

**PART I – TO BE COMPLETED BY THE EMPLOYEE**

<b>Member's Name (Last, First, Middle)</b>		<b>Social Security #</b>	<b>Date of Birth</b> / /	<b>Case Number</b> 10004 Div _____
<b>Member's Home Address</b>		<b>City</b>	<b>State</b>	<b>Zip Code</b>
<b>Association Name</b> Building Industry Association of Washington		<b>Sex</b> <input type="checkbox"/> M <input type="checkbox"/> F		<b>Date of Employment</b> / /
<b>Plan Choice</b> <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 4				
<b>Sponsoring Member Company Name</b>		<b>Marital Status</b> <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> Divorced/Legally Separated		
<b>Do you have an eligible spouse?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Number of eligible Children:</b>	<b>Indicate eligible dependents you wish to insure:</b> <input type="checkbox"/> None <input type="checkbox"/> Spouse <input type="checkbox"/> Children <input type="checkbox"/> Spouse & Children		

**DEPENDENT INFORMATION – Complete If You Are Applying For Family Coverage**

No person can be insured under this policy as both a Member and a dependent, or as a dependent of more than one Member. Please complete the following information for each family member you wish to cover.

<b>Dependents Name (Last, First, Middle)</b>	<b>Sex</b>	<b>Date of Birth</b>	<b>Relationship To Member</b>	<b>Full-Time Student</b>
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

**BENEFICIARY DESIGNATION**

**PRIMARY (P)** – The person(s) 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 (C)** - The person(s) 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.

**NOTE:** The Group Policyholder may not be named as a Beneficiary.

Full Name & Address	Date Of Birth	Relationship	Primary (P) Contingent(C)	% of Benefit

**This Is Important – Please Read**

A new Enrollment Form must be completed for any changes such as name change, beneficiary change, birth of a child, adoption of a child. The new form must be **dated, signed, and attached** to your original Enrollment Form.

**This Election for Coverage Cannot Be Processed Unless All Questions Are Answered And The Form Is Signed And Dated.**

**DECLINATION OF INSURANCE**

I have been given the opportunity to elect the Group Insurance Benefits as provided under a plan of Group Insurance established by my employer. I have decided **NOT** to elect this coverage. I understand that if I decide to elect this insurance at a later date, satisfactory proof of insurability will be required at my expense.

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date Signed

**YES, I DO WANT THIS COVERAGE.**

- I elect coverage for insurance for which I am or may become 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 Member Company pays 100% of the required contribution).**
- 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 at Symetra Life Insurance Company’s request, to the best of my knowledge and belief, is true and complete.

\_\_\_\_\_  
Member Signature

\_\_\_\_\_  
Date Signed

**PART II – TO BE FILLED OUT BY THE PARTICIPANT**

New Member                       Late Entrant Enrollee                       Open Enrollment

Change Requests – Effective Date of Change \_\_\_/\_\_\_/\_\_\_      Effective Date of Coverage \_\_\_/\_\_\_/\_\_\_

Case Number 10004 Division \_\_\_\_\_ Plan Choice  Plan 1     Plan 2     Plan 3     Plan 4