Regence
Life and Health Insurance Company

100 SW Market Street
P.O. Box 1271 E-3A
Portland, OR 97207-1271
(503) 721-7161 • (800) 794-5390

ENROLLMENT/CHANGE 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 page 2 of this form.
3. Sign, date and return this form to your Benefits Administrator.

LAST NAME	FIRST	INITIAL	BIRTHDATE Mo	Da	Yr	SEX M	F	SOCIAL SECURITY NO.

NAME OF EMPLOYER	OCCUPATION	HIRE DATE	GROUP NO.

Do you have dependents? (Spouse or Children) ☐ Yes ☐ No If "yes", do you wish to enroll them in Dependent Life Insurance coverage? (IF AVAILABLE TO YOUR GROUP) ☐ Yes ☐ No

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 Regence Life and Health Insurance Company under the Group lnsurance 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 Regence Life and Health Insurance Company.

☐ 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.

ALL PERSONS ENROLLING IN LIFE COVERAGE SHOULD COMPLETE THIS SECTION.

PRIMARY BENEFICIARY LAST NAME	FIRST (Given Name)	INITIAL	BIRTHDATE Mo	Day	Year	SEX M	F	SOCIAL SECURITY NO.
BENEFICIARY ADDRESS								RELATIONSHIP TO YOU
CITY	STATE	ZIP						**BENEFIT %**

PRIMARY BENEFICIARY LAST NAME	FIRST (Given Name)	INITIAL	BIRTHDATE Mo	Day	Year	SEX M	F	SOCIAL SECURITY NO.
BENEFICIARY ADDRESS								RELATIONSHIP TO YOU
CITY	STATE	ZIP						**BENEFIT %**

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

CONTINGENT BENEFICIARY LAST NAME	FIRST (Given Name)	INITIAL	BIRTHDATE Mo	Day	Year	SEX M	F	SOCIAL SECURITY NO.
BENEFICIARY ADDRESS								RELATIONSHIP TO YOU
CITY	STATE	ZIP						**BENEFIT %**

CONTINGENT BENEFICIARY LAST NAME	FIRST (Given Name)	INITIAL	BIRTHDATE Mo	Day	Year	SEX M	F	SOCIAL SECURITY NO.
BENEFICIARY ADDRESS								RELATIONSHIP TO YOU
CITY	STATE	ZIP						**BENEFIT %**

PLEASE SEE PAGE 2 FOR INSTRUCTIONS ON 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.

Insurance Fraud Warning: 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.

SIGNATURE OF EMPLOYEE	**DATE SIGNED**
EMPLOYER: Please complete this section if using this form for benefit enrollment.	☐ Hourly ☐ Annual
Group No. Effective Date Class Dept Salary $	☐ Monthly ☐ Other

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)
F.	Trustee	Mary R. Jones, Trustee, under trust agreement dated _____
G.	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.