

**To Be Completed By Human Resources (if applicable)**

Group Number <b>753117</b>	Division	Billing Category	Date of Employment
-------------------------------	----------	------------------	--------------------

**To Be Completed By Applicant**

- Apply for Coverage       Name Change      Former Name \_\_\_\_\_  
 Add Dependent       Delete Dependent      Date of Add/Delete \_\_\_\_\_  
 Beneficiary Change **Complete Beneficiary Section**

Your Full Name	Social Security Number	Birth Date	
Address	City	State	ZIP
Phone Number	Job Title/Occupation	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Employer Name <b>Jackson County School District 549c dba Medford School District</b>	Hours Worked Per Week		
Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year			
Spouse Full Name		Birth Date	

**Coverage**

*Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, Evidence Of Insurability requirements.*

<p><b>Life Insurance</b>  <input checked="" type="checkbox"/> Basic Life with AD&amp;D (Employer Paid)  <input type="checkbox"/> Additional Life with AD&amp;D (Employee Paid) requested amount \$ _____</p>
--

<p><b>Dependents Life Insurance</b>  <input checked="" type="checkbox"/> Spouse Life \$1,000 / Child(ren) Life \$1,000 (Employer Paid)</p> <p><b>Additional Dependents Life Insurance</b>  <input type="checkbox"/> Spouse Life with AD&amp;D (Employee Paid) requested amount \$ _____  <input type="checkbox"/> Child(ren) Life with AD&amp;D (Employee Paid) requested amount \$ _____</p>
---

<p><b>Short Term Disability Insurance</b>  <input type="checkbox"/> Short Term Disability (Employee Paid)</p>
---

<p><b>Long Term Disability Insurance</b>  <input checked="" type="checkbox"/> Long Term Disability (Employer Paid)</p>
--

Your Full Name

**Beneficiary**  
*This designation applies to your Life and Accidental Death and Dismemberment Insurance and Voluntary Accidental Death and Dismemberment Insurance, if any, available through your Employer. This designation also will apply to your Supplemental Life and Accident Insurance, if any, available through your Employer, unless replaced by a separate and later designation. Designations are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.*

Primary – Full Name	Address	DOB	Phone No.	SSN if known	Relationship	% of Benefit*
Contingent – Full Name	Address	DOB	Phone No.	SSN if known	Relationship	% of Benefit*

\*Total must equal 100%

**Signature**  
 I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Signature of Applicant (Member/Employee)	Date
--	------

Your Full Name

**Beneficiary Information**

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated \_\_\_\_\_."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.