

# Enrollment/Change Form

Basic Life and Basic AD&D Insurance, Supplemental Life and Supplemental AD&D Insurance, Short Term Disability Insurance, Long Term Disability Insurance provided by:

**UNIMERICA LIFE INSURANCE COMPANY OF CALIFORNIA**  
**10701 West Research Drive**  
**Milwaukee, WI 53226**



## TO BE COMPLETED BY EMPLOYER

Employer Name:		Policy Number:	
Employer Authorization:	Date of Hire: ____/____/____	Class:	
	Plan Variation/Reporting Code:	Plan:	
Requested Effective Date of Coverage / Date of Change: ____/____/____		<input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Change	
Reason: (Check the Appropriate Boxes)	<input type="checkbox"/> New Group Plan	<input type="checkbox"/> New Hire	<input type="checkbox"/> Annual Open Enrollment
	<input type="checkbox"/> Name Change	<input type="checkbox"/> Employee Terminated	<input type="checkbox"/> Marriage
	<input type="checkbox"/> Divorce	<input type="checkbox"/> Dissolution Domestic Partnership*	<input type="checkbox"/> Death
	<input type="checkbox"/> Adoption/Legal Custody	<input type="checkbox"/> Court Ordered Dependent	<input type="checkbox"/> Cobra/State Continuation
	<input type="checkbox"/> Other:		Start Date ____/____/____ End Date ____/____/____
		<input type="checkbox"/> Address Change	<input type="checkbox"/> Domestic Partnership*
		<input type="checkbox"/> Birth	

## EMPLOYEE INFORMATION

SS# _____ - _____ - _____	Employer Assigned ID#	Date of Birth: ____/____/____	
Last Name:	First Name:	Middle Initial:	
Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Email Address:	Annual Salary
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner *		
Employment Status: I am Actively at Work and have worked at my usual/required place of business for the past 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No			
I am scheduled to work _____ hours per week and have worked those hours for the past 30 days? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Employee Type (Check all that apply): <input type="checkbox"/> Active <input type="checkbox"/> Hourly <input type="checkbox"/> Salary <input type="checkbox"/> Union <input type="checkbox"/> Non-union <input type="checkbox"/> Retired <input type="checkbox"/> Other			

## BENEFIT ELECTIONS

Person	Basic Life	Basic AD&D	Supplemental Life	Supplemental AD&D
Employee	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
Spouse (or Dom.Part*)	<input type="checkbox"/> \$ _____		<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
Dependent	<input type="checkbox"/> \$ _____		<input type="checkbox"/> \$ _____	<input type="checkbox"/> \$ _____
	<input type="checkbox"/> Waive (if applicable)	<input type="checkbox"/> Waive (if applicable)	<input type="checkbox"/> Waive	<input type="checkbox"/> Waive
			Have you used tobacco of any kind in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			Spouse? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Person	STD	LTD	Life Insurance Beneficiary(ies) Full Name and Address	Relationship
Employee	<input type="checkbox"/> _____	<input type="checkbox"/> _____	1) _____ <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	
	<input type="checkbox"/> Buy-up	<input type="checkbox"/> Buy-up		
	<input type="checkbox"/> Waive (if applicable)	<input type="checkbox"/> Waive (if applicable)	2) _____ <input type="checkbox"/> Primary <input type="checkbox"/> Secondary	

FAMILY INFORMATION			Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)				
Check Appropriate Box	First Name	MI	Last Name (if different)	Date of Birth	Sex	Relationship**	Incapacitated***
	Dependent Social Security Number or Assigned ID						
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner*	Not Applicable
	SS#	_____ - _____ - _____					
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No
	SS#	_____ - _____ - _____					
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No
	SS#	_____ - _____ - _____					
<input type="checkbox"/> Enroll <input type="checkbox"/> Change <input type="checkbox"/> Cancel				___/___/___	<input type="checkbox"/> M <input type="checkbox"/> F	Dependent	<input type="checkbox"/> Yes <input type="checkbox"/> No
	SS#	_____ - _____ - _____					

\*A Domestic Partnership is established when both persons have filed a Declaration of Domestic Partnership with the State of California.

\*\*For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet.

\*\*\* Dependent is unmarried, financially dependent upon subscriber/covered person and is mentally or physically disabled. If answered "Yes" for Incapacitated, please attach medical certification of disability.

**AUTHORIZATION AND ACKNOWLEDGEMENT**  
(form must be signed)

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

All statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me or my beneficiary.

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected. I acknowledge that I have read the applicable Fraud Warning Notices provided below.

**FRAUD WARNING NOTICE:**

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.

Employee/Enrollee Signature: _____	Date: ___/___/_____
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