Plan Enrollment Application/Change Form

Plan Underwritten by Life Insurance Company of North America (LINA), through **New York Life Group Benefits Solutions.**

TO ALL FULL-TIME EMPLOYEES OF PARTICIPATING DEPARTMENTS

This is your opportunity to enroll in an excellent, low-cost Group Term Life Insurance Plan sponsored by your Department.

- If you **ELECT TO HAVE COVERAGE**, complete and sign the **APPLICATION** (Section I) or apply online at www.capitalins.com.
- If you desire to make a **policy change** (beneficiary or name), complete and sign the **POLICY CHANGE (Section II)**,

Attention: THIS FORM MUST REMAIN IN THE EMPLOYEE'S PERSONNEL FILE.

Caution: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I. APPLICATION FOR GROUP TERM LIFE INSURANCE COVERAGE

EMPLOYEE NAME _____ DOB _____ SSN _____

EMPLOYEE HOME ADDRESS _____

EMPLOYEE ID# _____ DEPT _____ DATE OF HIRE _____

COUNTY OF EMPLOYMENT _____ WORK PHONE _____ PERSONAL PHONE _____

PRIMARY BENEFICIARY NAME(S) _____ DOB _____ RELATIONSHIP _____ %

PRIMARY BENEFICIARY NAME(S) _____ DOB _____ RELATIONSHIP _____ %

CONTINGENT BENEFICIARY NAME _____ DOB _____ RELATIONSHIP _____ %

If more names are needed please complete additional form. If one or more primary or contingent beneficiary is listed the percentages must equal 100% for each.

I hereby apply for the amount of Group Term Life Insurance for which I am eligible under my employer's Group Insurance Plan. I authorize deductions from my earnings in the amount required to cover my premiums.

EMPLOYEE SIGNATURE _____ DATE _____

PERSONAL EMAIL _____

II. POLICY CHANGE ONLY

EMPLOYEE NAME _____ DOB _____ SSN _____

EMPLOYEE HOME ADDRESS _____

EMPLOYEE ID# _____ DEPT _____ PERSONAL PHONE _____

❑ BENEFICIARY CHANGE

PRIMARY BENEFICIARY TO: LAST NAME _____ FIRST NAME _____ RELATIONSHIP _____

PRIMARY BENEFICIARY TO: LAST NAME _____ FIRST NAME _____ RELATIONSHIP _____

CONTINGENT BENEFICIARY TO: LAST NAME _____ FIRST NAME _____ RELATIONSHIP _____

❑ NAME CHANGE

CHANGE MY NAME FROM _____ TO _____

EMPLOYEE SIGNATURE _____ DATE _____

III. BENEFICIARY DESIGNATION

The beneficiary for life insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request. If you need assistance, contact your benefits administrator at (800) 888-5256 or your own legal counsel.

IV. FOR PERSONNEL USE ONLY

PLEASE FILE ORIGINAL IN EMPLOYEE'S PERSONNEL FILE. **Fax a copy to Capital Insurance Agency. (850) 385-8126. DO NOT MAIL TO COMPANY**

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Samas Code	District/div Code	Effective Date of Insurance	Deduction Amount	Deduction Code	Date Processed/Initial