



SEANC INSURANCE DEPARTMENT
1621 Midtown Place
Raleigh, NC 27609

For SEANC Use Only:

Premium

Effective Date 1-01-2016 (2015 Annual Enrollment)

MEMBER:

INFORMATION - Amounts in excess of the guaranteed issue limit are available. Please contact SEANC Insurance Office at 800-222-2758 or 919-833-6436. Amounts in excess of the guaranteed issue or enrollment forms submitted after you first become eligible are subject to medical evidence of insurability satisfactory to Boston Mutual.

Member Name (Last, First, Middle Initial)

Social Security # Department/Agency

Member Address

Date of Birth Age Sex (M or F) Date of Hire Occupation Avg. Hours Worked

INSURANCE SELECTION (complete appropriate section)

New Life Insurance

OR

Guarantee Issue: (Member Only)

10,000
20,000

Member Life Insurance \$

Increase in Life Insurance

Current Insurance \$

Additional Insurance Requested \$

Total Requested Insurance \$

Beneficiary Information - Name of Beneficiary Residential Address Date of Birth Social Security # Tel.# Relationship Benefit %

Primary

Primary

Contingent Beneficiary

Contingent Beneficiary

If more than one beneficiary is designated, the proceeds will be split equally unless otherwise indicated. Please complete as much beneficiary information as you can provide.

SPOUSE/DEPENDENT CHILDREN:

INFORMATION: Spouse/Dependent Child(ren)

Spouse Life Insurance YES NO

Dependent Child(ren) Life Insurance YES NO

Spouse Name

Dependent(s)

Spouse Date of Birth

Dependent Dates of Birth

The beneficiary for the spouse and dependent children is the member.

I apply for the insurance for which I am now eligible (or for which I may become eligible) under the provisions of the group policy or group policies issued to SEANC by the Boston Mutual Life Insurance Company. I, the undersigned, hereby authorize my employer to deduct premiums for the SEANC insurance identified above from my wages/pension on a monthly basis, in such amounts as are currently established pursuant to the SEANC insurance contract with the provider, or in such adjusted amounts as may be established by SEANC and the provider by contract subsequent to the date of this authorization. This authorization shall continue until cancelled by me by written notice to the SEANC Central Office.

I understand that if I am disabled on the date my insurance would otherwise become effective, I shall only become insured on the date I return to active full-time work.

I further understand that if I decline insurance coverage for which I am now eligible and I desire to participate in the plan at a later date, I must furnish at my own expense, evidence of insurability satisfactory to Boston Mutual Life Insurance Company.

Signature of Member Date