

**INSURANCE ENROLLMENT FORM**

Please use this form to apply for coverage. Simply fill in any requested information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.



Life Insurance Company of North America

**EMPLOYER: Snow College**

**ALL ABOUT YOU – THE EMPLOYEE**

Your Name \_\_\_\_\_ SSN \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Home Address \_\_\_\_\_  
 Email \_\_\_\_\_ Home/Cell Phone \_\_\_\_\_ Employee ID # \_\_\_\_\_ Gender \_\_\_\_\_

**COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE OR DOMESTIC PARTNER\*\***

To be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or Affidavit on file with your employer.  
 I am currently married and my date of marriage is \_\_\_\_\_  
 I am currently in a Domestic Partnership and the date of formation of my Domestic Partnership is \_\_\_\_\_  
 Spouse Domestic Partner Name \_\_\_\_\_ SSN \_\_\_\_\_ Date of birth \_\_\_\_\_ Gender \_\_\_\_\_

**YOUR COVERAGE ELECTIONS**

View the Summary of Benefits for costs and instructions for how to calculate premium.

**Employer-Paid Term Life Insurance – Policy # FLX0969777 Underwritten by LINA**

The coverage below is provided by your employer at no cost to you.

Employee	The lesser of 2 times annual compensation or \$125,000 Guaranteed Issue Amount***: The lesser of 2 times annual compensation or \$125,000
Spouse or Domestic Partner	\$8,000 Guaranteed Issue Amount***: \$8,000
Children	\$8,000 Guaranteed Issue Amount***: All amounts

**Employee-Paid Term Life Insurance – Policy # FLX0969777 Underwritten by LINA**

Choose your desired coverage amount below and who you would like to cover. See the Summary of Benefits for costs.

Who You Want to Cover	Coverage Amount	Accept your desired coverage amount or decline coverage below.
<input type="checkbox"/> Employee	Units of \$10,000 up to the lesser of 5 times annual compensation or \$500,000 Guaranteed Issue Amount***: \$250,000	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$250,000*** <input type="checkbox"/> \$500,000**** <input type="checkbox"/> Other _____ Amount must be a multiple of \$10,000. <input type="checkbox"/> Decline Coverage
<input type="checkbox"/> Spouse or Domestic Partner	Units of \$5,000 up to \$250,000, not to exceed 100% of the employee's benefit Guaranteed Issue Amount***: \$50,000	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$50,000*** <input type="checkbox"/> \$250,000**** <input type="checkbox"/> Other _____ Amount must be a multiple of \$5,000. The amount cannot exceed 100% of the employee's coverage. <input type="checkbox"/> Decline Coverage
<input type="checkbox"/> Children	Units of \$10,000 up to \$10,000 Guaranteed Issue Amount***: All amounts	<input type="checkbox"/> Accept Coverage <input type="checkbox"/> Decline Coverage

If Children are elected, all eligible dependent children will be covered.

<b>Employer-Paid Accidental Death and Dismemberment Insurance (AD&amp;D) – Policy # OK0971217 Underwritten by LINA</b>	
<b>The coverage below is provided by your employer at no cost to you.</b>	
Employee	2 times your annual compensation up to \$125,000

\*\*\* Guaranteed Issue Amount is only available if enrolling within the first 31 days of eligibility. For any coverage that is not Guarantee Issue, you must complete the Evidence of Insurability Form. Amounts of insurance may be limited by state law.


\*\*\*\*This is the maximum coverage amount that you can choose under this plan. Coverage elected during this enrollment period will take effect on the later of 07/01/2026, the date your election form is received by your Employer, or if applicable the date your Evidence of Insurability Form is approved by the Insurance Company.

\*\*Domestic Partner is defined in the Group Policy. For purposes of this form, wherever the term Spouse appears, it shall also include Domestic Partner and Domestic Partners registered under any state which legally recognizes Domestic Partnerships or Civil Unions. Additional information is available from your employer. Spouse includes Partners in Civil Union relationships for residents of Vermont and State registered Domestic Partners for residents of Oregon.

**SIGN TO ACCEPT DEDUCTION FROM YOUR PAYCHECK**

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. I understand that coverage is subject to the insurance company's approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

**Caution:** Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

**Please Sign Here**  Signature \_\_\_\_\_ Date \_\_\_\_\_

Created on 10/2025.