COMPASS INSURANCE ENROLLMENT

ReliaStar Life Insurance Company, Minneapolis, MN

Administrative Office: PO Box 122, Minneapolis, MN 55440-0122

PLAN INFORMATION

Group Policyholder Name Washington County School District

Group Number 728497 Account Number 0001

ENROLLMENT TYPE

☐ Initial Eligibility ☐ Annual Enrollment ☐ Other _____

Proposed Effective Date of Coverage OR Date of Change *(mm/dd/yyyy)* _____

EMPLOYEE INFORMATION

Employee Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Birth Date *(mm/dd/yyyy)* _____ SSN _____ Gender: ☐ Male ☐ Female

Email Address _____

Residence Address _____ City _____ State _____ ZIP _____

Residence or Cell Phone (_____)_____ Work Phone (_____)_____

Hire Date *(mm/dd/yyyy)* _____ The Employee is Scheduled to Work _____ Hours Per Week

Job Title / Occupation _____

Employee ID Number _____ Employee Class _____

Pay Mode: ☐ Weekly ☐ Bi-Weekly ☐ Semi-Monthly ☐ Monthly ☐ Other _____

Department Number _____ Location Number _____

Is the Employee Actively At Work? . . . . . ☐ Yes ☐ No

COVERAGE REQUESTED

Critical Illness Coverage Election

☐ Employee	*(choose one)*:	☐ $15,000	☐ $30,000
☐ Spouse	*(choose one)*:	☐ $7,500	☐ $15,000
☐ Children	50% of the Employee Benefit		
☐ Waive			

Note: *Employee coverage is required in order to elect Spouse and Children coverage.*

Hospital Confinement Indemnity Coverage Election

Daily Benefit Amount: $200

☐ Employee
☐ Spouse
☐ Children
☐ Waive

Note: *Employee coverage is required in order to elect Spouse and Children coverage.*

Accident Coverage Election

☐ Employee
☐ Spouse
☐ Children
☐ Waive

Note: *Employee coverage is required in order to elect Spouse and Children coverage.*

Accidental Death Beneficiary *(All beneficiaries will share equally unless otherwise specified.)*

	Name *(First, MI, Last)*	DOB	Gender	SSN/TIN	Relationship to Employee	%	Beneficiary Type
1			☐ M ☐ F				☐ Primary ☐ Contingent
	Address			Phone ( )			
2			☐ M ☐ F				☐ Primary ☐ Contingent
	Address			Phone ( )			
3			☐ M ☐ F				☐ Primary ☐ Contingent
	Address			Phone ( )			

SPOUSE INFORMATION *(Complete only if applying for Spouse coverage.)*

Name *(First)* _____ *(Middle Initial)* _____ *(Last)* _____

Birth Date *(mm/dd/yyyy)* _____ Phone (_____)_____ SSN _____ Gender: ☐ Male ☐ Female

Address _____ City _____ State _____ ZIP _____

TOBACCO USE INFORMATION

Has the Employee used tobacco in any form in the last 12 months? . . . . . ☐ Yes ☐ No

Has the Spouse of the Employee used tobacco in any form in the last 12 months? . . . . . ☐ Yes ☐ No

REPLACEMENT

Is any insurance elected intended to replace any other accident and health insurance presently in force? . . . . . ☐ Yes ☐ No

ACKNOWLEDGMENTS AND SIGNATURE

Insurance benefits are contingent on proof of loss. Benefits may require medical information from your health care provider.

To the best of my knowledge and belief the information on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I authorize and instruct my Employer to deduct from my pay each pay period the premium due for my insurance coverage purchased through ReliaStar Life Insurance Company. This authorization will remain in effect until revoked by me in writing to my Employer. I understand that my coverage begins on the effective date assigned by ReliaStar Life Insurance Company, provided I am in active employment.

This enrollment form is subject to the terms and conditions of the Policy. I understand that no agent, representative or employee of ReliaStar Life Insurance Company, my Employer or any other entity may change or waive the requirements of this enrollment form, or the terms of the Policy, the Certificate or any riders, except as specifically set forth in the Policy.

The Policy / Policies provide limited benefits. Review your Certificate(s) carefully.

All statements and descriptions in the application are deemed to be representations and not warranties.

For Critical Illness Insurance: No person to be covered is also covered by any Title XIX program, designated as Medicaid or any similar name.

Employee Signature _____ Date _____

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