



**CONSUMERS LIFE
INSURANCE COMPANY**

A MEDICAL MUTUAL OF OHIO Company | *Health plans for life*

Employee Enrollment Form

Please Type or Print All Information

New Enrollment Change

24650 Center Ridge Road, Suite 110 • Westlake, Ohio 44145

Effective Date

Group Number

Last Name	First Name	M.I.	Date of Birth / /	Social Security Number
Street Address		City	State	Zip Code
Phone ()		E-mail		
Employer	Occupation/Job Title	Class	Gender <input type="checkbox"/> male <input type="checkbox"/> female	
Original Date of Hire	Date of Rehire (If Applicable)	Earnings <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Annual	\$	

COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to submit evidence of insurability.

BASIC COVERAGE(S)	(A)dd (D)etele	Total Amount of Coverage Applied for
Basic Life <input type="checkbox"/> YES <input type="checkbox"/> NO		
Basic AD&D <input type="checkbox"/> YES <input type="checkbox"/> NO		
Supplemental Life <input type="checkbox"/> YES <input type="checkbox"/> NO		
Supplemental AD&D <input type="checkbox"/> YES <input type="checkbox"/> NO		
Short-Term Disability <input type="checkbox"/> YES <input type="checkbox"/> NO		
Long-Term Disability <input type="checkbox"/> YES <input type="checkbox"/> NO		
Dependent Life <input type="checkbox"/> YES <input type="checkbox"/> NO		

BENEFICIARY DESIGNATION (For Employee Only: Must be completed if you have applied for Life or AD&D insurance). If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

LAST NAME	FIRST NAME	DATE OF BIRTH	RELATIONSHIP	BENEFIT %
Primary		/ /		%
Primary		/ /		%
Contingent		/ /		%
Contingent		/ /		%

I HEREBY REQUEST TO BE INSURED AND AUTHORIZE DEDUCTIONS, IF ANY, FROM MY COMPENSATION FOR MY SHARE OF THE COST OF THE BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE GROUP POLICY(IES) ISSUED TO THE EMPLOYER LISTED ABOVE. I UNDERSTAND THAT IF I AM NOT ACTIVELY AT WORK ON THE EFFECTIVE DATE OF COVERAGE, INSURANCE WILL NOT BEGIN UNTIL THE DAY I RETURN TO WORK. FOR THOSE COVERAGES I HAVE DECLINED, I UNDERSTAND THAT IF I CHOOSE TO ENROLL AT A LATER DATE, MY COST MAY BE HIGHER AND EVIDENCE OF INSURABILITY MAY BE REQUIRED.

EMPLOYEE SIGNATURE _____ DATE ____ / ____ / ____

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.