CONSUMERS LIFE INSURANCE COMPANY®
A MEDICAL MUTUAL OF OHIO COMPANY

17800 Royalton Road
Strongsville, Ohio 44136-5149

Employee Enrollment Form

Please Type or Print All Information

☐ New Enrollment ☐ Change

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 ☐ male ☐ female

Original Date of Hire	Date of Rehire (If Applicable)	Earnings ☐ Weekly ☐ Monthly ☐ Annual $ _____

COVERAGE SELECTION: Your 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)elete	Total Amount of Coverage Applied for
Basic Life	☐ YES ☐ NO		
Basic AD&D	☐ YES ☐ NO		
Supplemental/Voluntary Life	☐ YES ☐ NO		
Supplemental/Voluntary AD&D	☐ YES ☐ NO		
Short-Term Disability	☐ YES ☐ NO		
Long-Term Disability	☐ YES ☐ NO		
Dependent Life	☐ YES ☐ NO		

BENEFICIARY DESIGNATION (For Employee Only: Must be completed if you have applied for life and/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	/ /		%