ANGLICAN BENEFITS PROGRAM

EMPLOYEE BENEFITS ENROLLMENT / CHANGE FORM
PLAN YEAR – September 1, 2022 to August 31, 2023

*** EMPLOYEES MUST COMPLETE THIS SECTION *** Please Print or Type					
Employee Social Security #	Last Name		First Name	MI	
Are You Authorize to Work and Reside in the US?		Employed Full Time?	Employment Status	Hours Worked Per Week	
☐ Yes ☐ No		☐ Yes ☐ No	☐ Active ☐ Retired		
Mailing Address			City	State	Zip Code
Telephone Number	Work Email Address		Home Email Address		
Date of Birth	Gender	Marital Status	Place of Employment		
	☐ Male ☐ Female	☐ Single ☐ Married			
Date of Hire	Effective Date	Class	Salary (Annual)	Title	
		☐ Clergy ☐ Lay Person			
Enrollment Reason (Must Select One)					
☐ NEW ACNA Church/Initial Enrollment ☐ Qualifying Event (Birth/Marriage) ☐ Late Entrant ☐ Rehire ☐ Drop Coverage					

Spouse Information

Relationship	Last Name	First Name	MI	Date of Birth	Gender
Spouse					☐ M ☐ F

Employer Paid Life/AD&D Insurance #G-617336

American United Life Insurance Company Basic Life and AD&D Insurance	☐ Paid for by Employer	See benefit election form

Insurance Beneficiaries: Basic Life and AD&D AND Voluntary Life and AD&D ***MUST COMPLETE THE BELOW***

Primary Beneficiary Designation

Provide below the person(s) who should receive proceeds in the event of your death. You may specify as many individuals as you like, but the total percent share of proceeds must equal 100%.

Name of Primary Beneficiary(ies) (First, M.I., Last)	Relationship	Address	Social Security Number	Percent share
1.				
2.				

Secondary Beneficiary Designation

Provide below the person(s) who should receive proceeds ONLY if all of the individuals listed above are not living at the time of your death. If listing multiple persons, the total proceeds must equal 100%.

Name of Secondary Beneficiary(ies) (First, M.I., Last)	Relationship	Address	Social Security Number	Percent share
1.				
2.				

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Disability Insurance #G-617336		
American United Life Insurance Company Short-Term Disability Insurance	☐ Paid for by Employer ☐ Paid for by Employee ☐ Waive	60% of Weekly Earnings to a Max Benefit of $1,000 per week. See Benefit Guide for additional details.
American United Life Insurance Company Long-Term Disability Insurance	☐ Paid for by Employer ☐ Paid for by Employee ☐ Waive	60% of Monthly Earnings to a Max Benefit of $6,000 per month. See Benefit Guide for additional details.

American United Life Insurance Company Voluntary Life and AD&D Insurance #G-617336			
☐ **Employee Voluntary Life and AD&D**	☐ Waive	$_____ Voluntary Life and AD&D **Enter Total Amount (in increments of $1,000)** *The lesser of 5X annual earnings or $500,000* *Guaranteed Issue without Evidence of Insurability $110,000*	Refer to Table in Benefit Guide to determine cost based on your age and election amount.
☐ **Spouse Voluntary Life and AD&D**	☐ Waive	$_____ Voluntary Life and AD&D **Enter Total Amount (in increments of $500)** *The lesser of 100% of the Employee Life amount or $500,000* *Guaranteed Issue without Evidence of Insurability $25,000*	Refer to Table in Benefit Guide to determine cost based on your age and election amount.
☐ **Child Voluntary Life and AD&D**	☐ Waive	$_____ Voluntary Life and AD&D **Enter Total Amount (in increments of $2,000)** *The lesser of 100% of the Employee Life amount or $10,000* *(Live birth to 6 months: $1,000 max benefit)*	Refer to Table in Benefit Guide to determine cost based on your age and election amount.

You must elect coverage for yourself in order to have Spouse and/or Child coverage. The Voluntary Life coverage includes a Guarantee Issue Amount of $110,000 for Employee and $25,000 for Spouse. This applies to all eligible Employees enrolling in the Voluntary Life/AD&D coverage during their New Employee eligibility period. If coverage is not applied for during the New Employee eligibility period and is requested at a later date, the full amount of coverage being applied for will be subject to medical underwriting and an Evidence of Insurability form will be required. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

For your Dependent Spouse and Children, insurance coverage will be delayed if that Dependent is confined in any medical facility, rehabilitation center, convalescent care facility, nursing home or correctional facility on the date that insurance would otherwise be effective. Exception: Infants are insured from live birth.

I understand, agree and represent that I have read this document or it has been read to me and that the answers provided within this entire application for coverage are to the best of my knowledge and belief, and are true and complete. I understand that if any intentional material false statement, misrepresentation or omission is contained here my coverage could be reduced, denied or voided. I further authorize my employer to deduct from my earnings the contributions (if any) elected above. I understand the coverage may not become effective until I have satisfied my waiting period and/or been approved by Unum.

FRAUD WARNING: Any person, who, with intent to defraud by knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

EMPLOYEE SIGNATURE _____ **DATE** _____

If you live in a community property state, you will need to obtain the signature of your spouse if your spouse will not be named as a primary beneficiary. Community property states currently include: AZ, CA, ID, LA, NV, NM, TX, WA and WI.

In Community Property States, Spouse Signature _____ **DATE** _____