

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT	Your Name (Last, First, Middle)		Group Name <b>Washington Counties Insurance Fund (WCIF)</b>		Group Number(s) <b>645273</b>	
	Your Address		City		State	ZIP
	Your Soc. Sec. No.	Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Your Employer			Job Title/Occupation			
LIFE	Check with your Human Resources Department about coverage options available to you. <b>Voluntary Accidental Death and Dismemberment (AD&amp;D) Insurance</b> Employee must be insured under the plan to be eligible to elect coverage for the Spouse and or eligible Child(ren). <input type="checkbox"/> Employee Only    Your requested amount \$ _____ <input type="checkbox"/> Spouse <input type="checkbox"/> Child(ren)					
	This designation applies to Accidental Death and Dismemberment (AD&D) Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.					
BENEFICIARY	Primary - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
	Contingent - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
CHANGE	Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.					
	<input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent		<input type="checkbox"/> Name Change		<input type="checkbox"/> Beneficiary Change	
Date of add/delete _____		Former name _____		<input type="checkbox"/> Other _____		
SIGNATURE	I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.					
	Member/Employee Signature Required				Date (Mo/Day/Yr)	
<b>Human Resources Department - Complete this section. Retain form for your records.</b>						
Dvsn ID <b>0001</b>	Billing Cat. <b>0100</b>	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr		

## Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, “Dorothy Q. Smith, Trustee under the trust agreement dated \_\_\_\_\_.”
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer’s coverage under the Group Policy.