LifeMap Assurance Company®
P.O. Box 1271, M/S E8L
Portland, OR 97207
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(800) 794-5390

LifeMap Voluntary Benefits
Employee Enrollment and Change Form

For residents of California, Oregon and Washington, the definition of a Spouse includes your legal husband or wife or your State Certified/Registered Domestic Partner. Please contact your employer for any additional eligibility requirements.

For residents of Alaska, Idaho, Utah, Montana and Wyoming, the definition of a Spouse includes your legal husband or wife. Please contact your employer for any additional eligibility requirements.

Please complete using dark ink.

Employer Name			**Group Number**
☐ New Enrollment – Date of Hire/Rehire (mm/dd/yyyy)________________________________			☐ Change of Existing Enrollment
Employee's Name (Last, First MI)	Date of Birth	☐ M ☐ F	Social Security Number
Occupation			Annual Salary
Home Address (Street, City, State and Zip)			Telephone Number
Spouse Name (If applying for coverage)	Date of Birth	☐ M ☐ F	Social Security Number
Within the past 2 years has you or your spouse used cigarettes or other tobacco products? Employee ☐ Y ☐ N Spouse ☐ Y ☐ N			

If for any coverage (except AD&D and Accident Only) you select an amount OVER the Guarantee Issue Amount or are making application for any coverage AFTER your initial 31-day eligibility period, you must also complete and submit a LifeMap Evidence of Insurability Form.

Please indicate the total amount of voluntary coverage you wish to have for initial enrollment or when making changes to coverage.

Voluntary Life and Accidental Death and Dismemberment (AD&D) Insurance

Select Amount in $10,000 increments from a minimum of $10,000 to a maximum of $100,000.

Employee $ _______________ ☐ No Coverage Spouse $_______________ ☐ No Coverage

The beneficiary designation made for Basic Life Insurance, if provided, will apply unless you complete a separate beneficiary designation for Voluntary Life. Employee is the beneficiary of any Spouse or Child coverage. **For groups sited in Washington, Spouse coverage may not exceed 100% of Employee's benefit amount.**

Voluntary Life Accidental Death and Dismemberment (AD&D) Insurance for Children

Select Amount ☐ $10,000 ☐ No Coverage

You or your Spouse must be approved for Voluntary Life Insurance coverage in order for your Dependent Children to be enrolled.

Please continue application on the following page.

Note: The Accidental Death and Dismemberment (AD&D), the Critical Illness, the Accident Only and the Critical Illness and Accident Insurance Certificates provide limited benefits. Review your certificate carefully.

IMPORTANT: Your application for coverage is not complete if this page is not signed, dated and returned.

I request to be insured and authorize payroll deductions to cover the cost of coverage. Information in this application is given to obtain insurance, and the statements and answers are represented, to the best of my (our) knowledge and belief, to be true and complete. I (we) understand that (a) the insurance applied for shall not take effect until the application is approved and I will be notified of the insurance Effective Date; and (b) all insurance is subject to the eligibility provisions of the Policy; and (c) I must be Actively at Work (as defined in the Group Policy) to be insured. If I am not Actively at Work on the date my (our) coverage would become effective, my (our) coverage will not begin until the day I return to work.

Insurance Fraud Warning:

Unless specific state language is provided below, the following general fraud notice applies: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

For residents of Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

If your answers on this application are incorrect or untrue, LifeMap Assurance Company has the right to deny benefits or rescind your coverage for up to two years from the date coverage becomes effective.

▶ ______________________________ ▶ ______________________

Employee Signature | Date Signed

▶ ______________________________ ▶ ______________________

Spouse Signature (if applying for coverage) | Date Signed