SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
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LIFE INSURANCE ENROLLMENT

TO BE COMPLETED BY THE EMPLOYER

Policy # _____

Employer/Policyholder Name _____

Street Address _____ City _____ State _____ Zip Code _____

Employee Occupation/Job Title _____ Employee Date of Employment _____

Effective Date of Coverage _____ ☐ Full Time Employee ☐ Part Time Employee

$_____ / ☐ HR ☐ WK ☐ MO ☐ YR
Basic Earnings

Class Number (if applicable) _____

I. EMPLOYEE INFORMATION

Name _____ Sex ☐ M ☐ F

Street Address _____ City _____ State _____ Zip Code _____

Home Telephone Number _____ Date of Birth _____ Marital Status _____

II. BENEFITS (Please check if you wish to enroll and include the benefit amount)

	Yes	No	
Employee Life			x BAE* or $
Employee AD&D			x BAE* or $
Employee Supplemental Life			x BAE* or $
Employee Supplemental AD&D			x BAE* or $
Dependent Life			
Spouse			x BAE* or $
Child			x BAE* or $
Spouse & Child			x BAE* or $
Dependent AD&D			
Spouse			x BAE* or $
Dependent Supplemental Life			
Spouse			x BAE* or $
Child			x BAE* or $
Spouse & Child			x BAE* or $
Dependent Supplemental AD&D			
Spouse			x BAE* or $
Other			x BAE* or $
Other			x BAE* or $
Other			x BAE* or $

BAE: Basic Annual Earnings as defined in your contract

III. BENEFICIARY DESIGNATION

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

	NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP	% OF BENEFIT
☐ Primary					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

IV. SELECTION/WAIVER OF GROUP INSURANCE

I, the undersigned, an employee of the above-named policyholder, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance **(Not applicable if the [Employer] pays 100% of the required contribution).**

I hereby waive my right at this time to elect the insurance coverages which I did not select above. I understand that if I do not enroll within 31 days, when first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death.

All information submitted by me on this form to the best of my knowledge and belief is true and complete.

Employee Signature _____ Date Signed _____