

Enrollment/Change Form

Please print and complete all sections.

See instructions below.

Underwritten by Fidelity Security Life Insurance Company of
Kansas City, Missouri

EMPLOYER INFORMATION:

Group Number 9729526	Employer Name	Plan Selection <input type="checkbox"/> Option 1 <input type="checkbox"/> Option 2 <input type="checkbox"/> Option 3	Hire Date	Effective Date
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EMPLOYEE INFORMATION

<input type="checkbox"/> ADD <input type="checkbox"/> TERM <input type="checkbox"/> CHG	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Member ID (SSN)	Last Name	First Name	MI	Date of Birth
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Home Street Address	City/State/ZIP+4	Home Phone ()
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FAMILY INFORMATION (Only those eligible may be enrolled.) A: Add (enroll) T: Terminate C: Change (change of name)

<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (spouse)	First Name	MI	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	MI	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	MI	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	MI	Date of Birth	Social Security Number
<input type="checkbox"/> A <input type="checkbox"/> T <input type="checkbox"/> C	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Last Name (dependent)	First Name	MI	Date of Birth	Social Security Number

I agree to continue enrollment until canceled due to IRS-qualifying event or canceled by me during annual open enrollment. I further authorize applicable payroll deduction, where available, for premiums due.

Employee Signature: _____ Date: _____

Employer Signature: _____ Date: _____

Instructions:

Effective date: The day you become eligible.

Family Information: List only eligible family members who are enrolling.
Dependent eligibility is up to age 26.

(A) Add: Open enrollment or new hire.

(T) Terminate: To terminate enrollment.

(C) Change: A change of name, employee address or employee phone.

Completed forms must be returned to Brethren Insurance Services **WITHIN 31 DAYS OF YOUR HIRE DATE**. If you miss the initial 31-day enrollment period, you may be eligible for late enrollment for life and/or disability coverage. Also, keep in mind that we offer an annual open enrollment for our dental, vision, life and AD&D, long- and short-term disability, and accident plans.