# INSURANCE ENROLLMENT FORM

**Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.**

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Offered by Life Insurance Company of North America

**Employer:** Archdiocese of Baltimore

## ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ **Social Security #** _____ **Birthdate** _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Gender: _____

## COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE

❑ I am currently married and my date of marriage is: _____

***My Spouse's Information***

Name _____ **Social Security #** _____

Birthdate _____ Gender _____

## YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

| **Employer-Paid (Basic) Term Life Insurance Policy # FLX 980067** | | |
|---|---|---|
| **Applicant** | **The coverage below is provided by your employer at no cost to you.** | |
| Employee | 2 times your salary up to $100,000 | Guaranteed Coverage: Lesser of 2 times your salary or $100,000 |

| **Employee-Paid (Voluntary) Term Life Insurance Policy # FLX 980067** | | |
|---|---|---|
| **Applicant** | Available Coverage | Accept your desired coverage amount or decline coverage below. |
| Employee | 0.5, 1.0 or 2.0 times your salary to maximum of $250,000.<br><br>Guaranteed Coverage: Lesser of 2 times salary or $250,000 | ❑ 0.5<br>❑ 1.0<br>❑ 2.0<br><br>❑ Decline Coverage |
| Spouse | ❑ $10,000<br>Guaranteed Coverage*: $10,000 | ❑ Decline Coverage |
| Child | ❑ $5,000 | ❑ Decline Coverage |

***This is the maximum amount that you can choose under this plan.*
*All coverage elected during this enrollment period will take effect on the latest of 07/01/2023, the date your election form is received by your employer, or if applicable the day your Evidence of Insurability Form is approved by the Insurance Company.*

## SIGN HERE TO ACCEPT YOUR DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to New York Life Group Benefit Solutions' approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by MD: Life Insurance Company of North America.

**Please Sign Here** ☛ Signature _____ Date _____

Created on 06/2023.