CITY OF PINE BLUFF
Group Employee Application
Group #00053673

CHECK ONE:

☐ New Enrollee ☐ Add/Remove Dependents ☐ Cancel Coverage

☐ Change of Information Effective Date: (/ /)

Section 1. EMPLOYEE INFORMATION

Last Name	First Name	MI	Date of Birth	Gender	SSN
			/ /		- -
Address		City		State	Zip Code
Home Phone #	Cell Phone #	Department			Full-time Hire Date / /
Email Address					

Section 2. COVERAGE SELECTION (check one)

☐ Employee Only ☐ Family Coverage (2 or more people)

Section 3. DEPENDENT INFORMATION

Add	Remove	Full Name (First, MI, Last)	Relationship	Home Zip Code	Date of Birth	Gender	SSN
					/ /		- -
					/ /		- -
					/ /		- -
					/ /		- -
					/ /		- -

Section 4. OTHER INSURANCE (if applicable)

Are any of the members listed above covered by another insurance company?	☐ Yes ☐ No
On the day coverage begins, will any family members listed above be covered by Medicare? If yes, please answer all questions below.	☐ Yes ☐ No

Reason for Medicare coverage: ☐ Over 65 ☐ Disabled ☐ Kidney Disease

Medicare Health Identification Contract (HIC) Number:

Type of Medicare Coverage (check all that apply): ☐ Medicare Part A—Eff. Date: / / ☐ Medicare Part B—Eff. Date: / /

Section 5. SIGNATURES (please read before signing)

This is to certify that I have received information on the Benefit Program, and understand the benefits, limitation and exclusion, including pre-existing conditions and coordination of benefits. The statements and answers on front of this application are complete and true to the best of my knowledge and belief, and I understand that the answers to questions shall be basis of any coverage issued; and that any incorrect answers may operate to void coverage. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records, or knowledge of me or my dependents to give my Employers/Administrator, its legal representatives or its reinsurers any information about me or any dependent applied for, concerning medical history, and mode of living.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Signature: ______________________ **Date:** ____________

Group Administrator: ______________________ **Date:** ____________

Section 6. WAIVER (if applicable)

The Affordable Care Act requires all individuals to have minimal health insurance coverage or it may result in a penalty. By signing this, I understand that I am waiving my coverage with the City and cannot enroll until the open enrollment period or I have a qualifying event.

Employee Waiver Signature: ______________________ **Date:** ____________

DELTA DENTAL

ENROLLMENT/CHANGE FORM

Delta Dental of Arkansas
P.O. Box 15965
North Little Rock, AR 72231
E-mail: eligibility@ddpar.com
Fax (501) 992-1890

☐ New Enrollment ☐ Status Change ☐ Address Change ☐ Termination
☐ Dental Only ☐ Vision Only ☐ Dental/Vision ☐ Cobra

Effective Date

Month	Day	Year

Group Number: 2610 2610V

Group Name: City of Pine Bluff

Social Security Number ______

Subscriber's Identifier (if applicable) ______

LAST NAME: ______ FIRST: ______ MI: ______

STREET ADDRESS: ______

CITY: ______ STATE: ______ ZIP: ______

EMAIL: ______

Date of Birth / / MM DD YY

Marital Status ☐ Single ☐ Married

Sex ☐ Male ☐ Female

Date of Hire / / MM DD YY

NOTE: Certain medical conditions may entitle you and/or your covered dependents to additional benefits. Please mark any conditions that apply to you (Under section 2 below, please enter Code for affected dependents in the box entitled "EBD Code." Enter P for pregnant, D for diabetes, and H for Heart Disease)

☐ Pregnancy - Expected due date ______
☐ Diabetes - Date of onset ______
☐ Heart Disease - Date of onset ______

1. COVERAGE CHANGES

* Please check the box(es) next to the reason(s) for your change

Type coverage selected (choose one)

Dental	Vision
☐ Employee	☐ Employee
☐ Employee/Spouse	☐ Employee/Spouse
☐ Employee/Child	☐ Employee/Child
☐ Employee/Children	☐ Employee/Children
☐ Employee/Family	☐ Employee/Family

☐ Add Dependent(s) **listed below**
☐ Remove Dependent(s) **listed below**
☐ Name Change
☐ Late Entrance (employee)

☐ Change Coverage
☐ Address Change only
☐ Qualifying event
☐ Late Entrance (dependent)

Reason(s) for Change:
☐ Marriage
☐ Divorce
☐ Birth or adoption of child
☐ Full Time Student
☐ Handicapped
☐ Other ______
☐ COBRA effective date ______

Date of event ______
☐ Loss of spouse's coverage
☐ No longer dependent child
☐ Death of dependent
☐ No longer Full Time Student
______

2. LIST ALL MEMBERS TO BE ENROLLED OR AFFECTED BY CHANGE

Dental	Vision	Add	Remove	EBD Code	Onset Date	Last (if different)	First	MI	Relationship	Sex M/F	Birthdate (MM/DD/YY)
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								
☐	☐	☐	☐								

3. AUTHORIZATION

I authorize dentists, dental office personnel, and other health care professionals and entities to disclose to Delta Dental of Arkansas, its agents and employees (including, without limitation, its claims and customer service personnel) all information necessary to determine (1) eligibility for coverage and (2) covered benefits. This authorization is made for each individual to be enrolled or affected by this change. The authorization is valid for 30 months from the date this form is signed for the purpose of collecting information in connection with enrollment, coverage reinstatement, or requests to change benefits. The authorization is valid for the term of coverage for the purpose of collecting information in connection with claims for benefits. The applicant or the applicant's authorized representative is entitled to receive a copy of the authorization form.

4. CERTIFICATION

I certify that the information supplied by me on this form is accurate to the best of my knowledge. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

☐ I have been offered the opportunity to enroll in the dental and/or vision program through Delta Dental; however, **I waive coverage at this time.**
☐ I authorize payroll deductions.

Signature: ______ Date: ______

enrollment/change/waiver

group insurance form

Policy and Div. # 010- 407-615-1 Cert. #

COBRA: If individual is a continuee
Qualifying Event ______
Date of Event ______

LIFE INSURANCE CORP.
P.O. Box 30284
Tampa, FL 33630-3284
877-803-5357 / Fax: 877-457-2201

Name and Address of Employer (Policyholder) City of Pine Bluff

1 **to enroll** ☐ Dental ☐ Eye Care ☐ To terminate all coverages VSP Vision Plan

employee information

Marital Status ☐ Single ☐ Married ☐ Civil Union* ☐ Domestic Partner* *As defined by state law or your Group.

Social Security number ______ Dept. number ______

Employee's last name, first name, MI ______

Date of birth ______ ☐ Male ☐ Female

Full time date of hire ______ ☐ Rehire: Rehire date ______

Occupation ______

Hours worked each week ______ Are your earnings paid: ☐ Hourly or ☐ Salaried

Street address ______ City ______ State ______ ZIP ______

E-mail address (limit of 60 characters) ______

Are you covered under another **dental** insurance plan? .... **Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

Are you covered under another **eye care** insurance plan? .... **Employee:** ☐ Yes ☐ No **Dependents:** ☐ Yes ☐ No

dependent coverage information List all eligible dependents to be added or deleted. (Employee must be enrolled to cover dependents)

print full legal name (last, first, MI)	dental add	eye care add	dental drop	eye care drop	relationship	sex	date of birth	social security no.	college student?
1									
2									
3									
4									
5									

please sign (employee/policyholder) **The certificate provides dental and eye care benefits only. Review your certificate carefully.**
As an employee, I hereby apply for, or waive (if indicated), group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. *THE FOLLOWING APPLIES ONLY TO SECTION 125 FLEXIBLE BENEFITS PLANS:* I am signing up for coverage until the next enrollment period except in the case of a life event. This information was explained in the plan's solicitation materials which I have read and understand. I represent that the information I have provided is complete and accurate to the best of my knowledge. The policyholder certifies the date of employment, job title, hours worked and salary information are correct according to the Policyholder's records.

X ______ Date ______
Employee Signature (do not print)

X ______ Date ______
Policyholder Signature (do not print)

Agent name ______ Agent # ______ Agent License # ______

In several states, we are required to advise you of the following: Any person who knowingly and with intent to defraud provides false, incomplete, or misleading information in an application for insurance, or who knowingly presents a false or fraudulent claim for payment of a loss or benefit, is guilty of a crime and may be subject to fines and criminal penalties, including imprisonment. In addition, insurance benefits may be denied if false information provided by an applicant is materially related to a claim. (State-specific statements on back.)

Employee late entrant date ______

Dependent late entrant date ______

Effective Date	Class	Dep. Code

2 **to change**

☐ **Name change** New Name ______ Old Name ______

☐ **Add dependent coverage**

☐ If due to marriage, what is the date of marriage? ______ ☐ If due to birth/adoption, what is the date of event? ______

☐ If due to loss of coverage, date and reason: ______

☐ If other, the date of event and please explain: ______

☐ **Drop dependent coverage** Number of dependents still covered: ______ Effective date of drop: ______

☐ Due to divorce ☐ Due to death ☐ Due to annual election period ☐ Exceeds maximum age to qualify as dependent

☐ Other (please explain) ______

3 **to waive** IF YOU DO NOT WANT COVERAGE, COMPLETE THE WAIVER SECTION. THE WAIVER MAY NOT BE ALLOWED FOR THIS PLAN, CHECK WITH YOUR EMPLOYER. I have been given an opportunity to apply for Group Insurance offered by my employer, and have decided not to accept the offer for:

☐ myself (does not apply to TRUST policies) ☐ spouse/domestic partner ☐ child(ren) only ☐ spouse/domestic partner and child(ren)

because ______

Name of insurance company and employer of dependent ______

Should I desire to apply for this group insurance in the future, I realize that a "late entrant" penalty may be applied.

Lincoln Financial Group®

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: PINEBLUFF	GROUP POLICY #:	Billing Division or Location:

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print) City of Pine Bluff			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Spouse Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single		Home Phone ( )		Work Phone ( )

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐Hourly ☐Monthly ☐Weekly ☐Yearly $________	Date of Full-Time Employment:	Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

Basic Coverage NOTE: Please mark the box or boxes for each coverage you are applying for.
All coverage amounts are subject to the limitations and exclusions as stated in the policy.

Class	Effective Date	Type of Coverage	Amount of Coverage	Total Premium
		Short Term Disability ☐Yes ☐No*	$	$
		Long Term Disability ☐Yes ☐No*	$	$

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

E. Request for Coverages

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

- ☐ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby enroll for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
- ☐ **NOT ENROLL myself in the Program.** I understand that if I enroll for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.
- ☐ **NOT ENROLL my dependents in the Program.** I understand that if I enroll for coverage for my dependents at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTE: A PERSON MAY BE COMMITTING INSURANCE FRAUD, IF HE OR SHE SUBMITS AN APPLICATION OR CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not Actively at Work or an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name:________________ Employee Signature:________________ Date:________

Allstate Voluntary Benefits Enrollment
for the City of Pine Bluff

The value of voluntary supplemental insurance can be measured during a time of need - an accident, a disabling injury, an illness or death. Allstate Benefits provides the right voluntary insurance products - health, life, disability, vision and dental - that can be customized with various levels of coverage. Everyone should be able to access quality insurance from a company they trust.

How do I sign up? It is easy to enroll. Contact a Benefit Representative to review the information. You can also contact Santa Cruz Insurance Group for enrollment support, at 1-228-463-0033, ext 21.

Paying for Coverage: These plans are paid by the employee through payroll deduction.

Employees must have information about dependents & beneficiaries in order to enroll family members- so have that information available when you call: Date of Birth, Socials, Medications taken (prescription information), Doctors name if under a doctors care.

What are the plans and why would I need them?
The following are the benefits available to you through The City of Pine Bluff:

Critical Illness
Accident
Cancer
Universal Life
Term Life

Critical Illness Insurance provides a lump sum benefit which is paid directly to you upon diagnosis with one of the covered critical illnesses. You can choose benefit amounts of $10,000 up to $20,000 and benefits are paid directly to you regardless of any other health coverage you may have and are portable at the same rate.

Accident Insurance pays benefits directly to you, regardless of any other health coverage you have. This plan itemizes your injury and pays according to a schedule of benefits.

Example:		
	Visit to the Emergency Room	500.00
	Broken Arm	2,145.00
	Ambulance	200.00
	Initial Hospitalization	1,000.00
	Follow Up Visit (2)	50.00

Cancer Insurance provides scheduled benefits for the treatment of Cancer. Benefits included First Occurrence which is a lump sum payment upon diagnosis. Other benefits include; Chemotherapy and Radiation Treatment, hospitalization, surgery, travel, lodging, etc.

Universal Life Insurance is a permanent life coverage in which premiums remain the same throughout the life of the policy and plan does not terminate after the "term" expires. This plan allows you to choose coverage amounts up to $150,000.

☐ yes ☐ no
Request a representative to contact you

Employee Signature Date

Contact Number

Notice: This benefit summary provided by Santa Cruz Insurance Company (Enrollment Firm) is designed to highlight the benefits of the plan and DOES NOT detail all benefits, limitations, and exclusions. It is not a contract and may be subject to change. For more detailed information consult your contract or certificate of coverage and you should discuss, in detail, the policies you are interested in with an agent at the enrollment. The policy you receive in the mail is the actual contract and details the benefits you have chosen during enrollment. Please refer to your policy once received and contact us if you feel the benefits chosen during enrollment differ from your actual policy. Employees must be actively at work to apply for coverage. Pre-existing exclusions will apply for some benefits.

CITY OF PINE BLUFF, ARKANSAS

DEPARTMENT OF HUMAN RESOURCES
200 East 8th Avenue, Suite 104
Pine Bluff, Arkansas 71601
(870) 730-2038
Fax (870) 730-2157

JRMC Wellness/JRMC White Hall Health Center Form

Employee Name: ______________________________

Employee ID #: ______________ Department: ______________

☐ New Enrollment ☐ Transfer from Public to Corporate Rate

☐ Cancellation of Membership (Complete form in its entirety, incomplete forms will not be processed.)

I authorize a deduction from my bi-weekly earnings for participation in the JRMC Wellness Center as outlined below. Deductions will be made on a bi-weekly basis.

Upon completion, please take this form to the Wellness Center facility and pay the initial joining fees listed below. The Wellness Center will return the form back to the City of PB.

Joining Fees:

Adult Joining Fee	$25.00 Payable to the Wellness Center at time of enrollment
Child Joining Fee	$10.00 Payable to the Wellness Center at time of enrollment

Check One:	***Membership Type:***	***Monthly Rate:***
☐	Individual only	$40.00
☐	Individual + 1	$50.00
☐	Individual + 2	$55.00
☐	Individual + 3	$60.00
Total		______

ALL MEMBERS MUST BE PRESENT AT TIME OF REGISTRATION.

At anytime membership is cancelled with the JRMC Wellness Center, a cancellation form must be completed in the Human Resources Department, **prior** to the 15th of the month. Cancellation after the 15th of the month will result in dues deducted for the following calendar month. HR will fax cancellation requests to JRMC upon receipt.

Payroll Effective Date: ______________

Employee Signature/Date: ______________________________

JRMC Wellness Center/Date: ______________________________

City of Pine Bluff HR/Date: ______________________________

Submit form to: JRMC Wellness Center 1301 W. 40th Ave., Pine Bluff, AR 71603
Phone: 870-541-7890 / Fax: 870-541-7326

(*) Mandatory life insurance - City pays!

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

OFFICE CODE: | Memo

Please Use Ink or Type | GROUP ID: 65472 | GROUP POLICY #: 00012AS00012

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print): City of Pine Bluff		County: Jefferson	State: AR
Social Security Number	Last Name	First Name	MI
Street Address	City	State	Zip	Date of Birth
☐ Male ☐ Female	Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed	Spouses Date of Birth	Home Phone ( )	Work Phone ( )

Completed By Employer

Effective Date:	Date of Full-Time Employment:	Occupation:
Earnings: $ ☐ Hourly ☐ Monthly ☐ Weekly ☐ Yearly	☐ Union ☐ Exempt ☐ Non-Union ☐ Non-Exempt	Average Hours Worked Per Week: / Rehire Date:

B. Product Selection (Complete for ALL Enrollments)

NOTE: Please mark each box if you are eligible for the listed coverage.

Class	Effective Date	Basic Amount *Employer to Complete*	Coverage			Amount
			Group Life	☑ Yes	☐ No	
			Group AD&D	☑ Yes	☐ No	
			Dependent Life	☐ Yes	☐ No	
			Optional Employee Life	☐ Yes	☐ No	
			Optional Dependent Life	☐ Yes	☐ No	
			Optional AD&D	☐ Yes	☐ No	

C. Beneficiary Information (Complete ONLY for Life or AD&D Enrollments)

Primary Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address		City	State	Zip
Contingent Beneficiary's Last Name	First	MI	Relationship of Beneficiary	Social Security Number
Street Address		City	State	Zip

Note: A Contingent Beneficiary will receive benefits only if the Primary Beneficiary does not survive you. If you wish to designate more than one Primary or Contingent Beneficiary, please attach a separate sheet of paper.

D. Signature (Complete for ALL Enrollments)

I hereby apply for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary. I reserve the right to revoke this deduction at any time on written notice.

Employee Signature ____________________ Date Signed ____________

Dental Enrollment is on the back of this Enrollment Form.

The Lincoln National Life Insurance Company, PO Box 2616, Omaha, NE 68103-2616
toll free (800) 423-2765
www.LincolnFinancial.com

Please fax to (877) 573-6177
Total Pages Faxed ________

GROUP INSURANCE CHANGE REQUEST

Employer: City of Pine Bluff

Policy Number (List all affected policy numbers): 00012 AS 00012

Group ID: 65472 Insured's Name: ________ Social Security Number: ________

NAME/ADDRESS CHANGE (First, MI, Last):
From:
To:

BENEFICIARY CHANGE	
Primary Beneficiary:	Relationship:
Contingent Beneficiary:	Relationship:
NOTE: Contingent Beneficiary will receive benefits only if Primary Beneficiary does not survive you. If more than one Primary or Contingent Beneficiary is wanted, please attach a separate sheet of paper.	

DEPENDENTS TO BE ADDED OR REMOVED

Check One		Name (First, MI, Last)	Date of Birth (Mo/Day/Yr)	Relationship (Spouse or Child)	Date of Marriage (Mo/Day/Yr)	Late Entrant (Yes or No)
Add	Remove					

If adding dependent outside eligibility period, please explain reason:

For foster or adopted child, show date or placement and any adoption decree.

NOTE: If dependents are late entrants for Life coverage, each dependent will need to complete an Evidence of Insurability form and submit it to The Lincoln National Life Insurance Company for review. If dependents are late entrants for Dental coverage, and were previously covered under another plan, please complete the back of this form.

CHANGES IN COVERAGE (For Changes to Accident Coverage see page 2.)

Effective Date of Change: ________ **Current Salary: $** ________

☐ 1. Increase Employee Coverage to $ ________ ☐ 2. Add/Increase Spouse Coverage to $ ________ ☐ 3. Add/Increase Child Coverage to $ ________

Indicate which coverage the above change is for (ex. Vol life, Optional life, Critical Illness, etc.): ________

Enrollment form must be attached for items 1 - 3. Evidence of Insurability may be required.

Effective Date of Change: ________

☐ 1. Reduce Employee Coverage to $ ________ ☐ 2. Reduce Spouse Coverage to $ ________

Indicate which coverage the above change is for (ex. Vol life, Optional life, Critical Illness, etc.): ________

Date:	Insured's Signature:	Witness' Signature:

Lincoln Financial Group is the marketing name for Lincoln National Corporation and its affiliates.

Lincoln Financial Group®

The Lincoln National Life Insurance Company, PO Box 2616, Omaha, NE 68103-2616
toll free (800) 423-2765 Fax (877) 573-6177
www.LincolnFinancial.com

BENEFICIARY DESIGNATION FORM

Policyholder/Employer	Policy Number(s)
Employee Name	Employee Social Security or Certificate Number
Employee Address (Street, City, State)	Employee Telephone Number

WHO ARE YOUR BENEFICIARIES?

It is very important to clearly indicate your primary beneficiary(ies) and contingent beneficiary(ies). Proceeds are paid to contingent beneficiary(ies) only if there is no surviving primary beneficiary(ies). If multiple primary beneficiaries or contingent beneficiaries are named and no percentage distribution is noted, then any proceeds payable to such beneficiaries will be split equally. If more space is needed to list your beneficiaries please attach a sheet to this form. **The beneficiary(ies) named on this form will be valid for all basic, optional, and/or voluntary group term life and AD&D coverages unless otherwise indicated by you. The beneficiary designation may not go into effect until this form is signed and dated by you. Page 2 of this form includes examples of how to complete this form.**

PRIMARY BENEFICIARY(IES)

Primary Beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: Address:				
Name: Address:				
Name: Address:				

CONTINGENT BENEFICIARY(IES): Contingent beneficiaries will only receive benefit if there are no surviving primary beneficiaries.

Contingent Beneficiary's Name and Address	Social Security Number	Relationship to You	Date of Birth	Percentage: Must equal 100%
Name: Address:				
Name: Address:				
Name: Address:				

Community Property State Consent for residents of Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin. If you are married, live in a community property state, and name someone other than your spouse as beneficiary, you may have your spouse sign below to waive his or her rights to any community property interest in the benefit.

As the Insured's spouse, I do hereby consent to the beneficiary designation(s) indicated on this form and waive any rights that I may have to the proceeds of such insurance under applicable community property laws.

Signature of Spouse ____________________ Date ____________

Signature of Employee ____________________ **Date** ____________