MARSHALL ISLANDS GOVERNMENT
GROUP LIFE INSURANCE ENROLLMENT FORM

Choose One: ☐ Re-Enrollment ☐ New Enrollee ☐ Change Coverage* ☐ Cancel Coverage** ☐Transfer Employers***

* Reason for Change: _____ Change Date: ____/____/_____

** Reason for Cancellation: _____ Cancellation Date: ____/____/_____

*** Transfer from: _____ Transfer Date: ____/____/_____

Last Name	First Name	Middle Name
Mailing Address		Date of Birth
		Sex ☐ Male ☐ Female
Email Address	Phone Number	Social Security Number
Government Department	Employment Date	Marital Status ☐ Married/Common-Law ☐ Single

Employment Status

☐ Active

1. Do you work 20 or more hours per week? ☐ Yes ☐ No **IF YOU ANSWER NO, YOU ARE NOT ELIGIBLE FOR COVERAGE.**
2. Are you presently on leave of absence from work due to sickness (other than a cold or the flu,) injury, medical treatment, or unpaid leave of absence for personal reasons? ☐ Yes ☐ No If yes, identify the reason(s), date leave of absence began, and date expected to return to work. New coverage will not take effect until the first day you return to active work and meet all other requirements to effect the coverage.

_____

_____

☐ Retired

Name of employer retired from: _____

EMPLOYEE & RETIREE TERM LIFE INSURANCE Available to Active Employees and Retirees

☐ I want to enroll for Employee & Retiree Term Life Insurance.

☐ I do NOT want to enroll for Employee & Retiree Term Life Insurance; which also waives my right to Dependent Term Life Insurance. **If I choose this option, no life insurance coverage will be in force.**

Beneficiaries The total of the Percentage column must equal 100%, or check here ☐ for equal shares.

Last Name	First Name	Middle Name		
Date of Birth	Social Security Number	Phone	Relationship	%
Address		Email Address		

Last Name	First Name	Middle Name		
Date of Birth	Social Security Number	Phone	Relationship	%
Address		Email Address		

Last Name	First Name	Middle Name		
Date of Birth	Social Security Number	Phone	Relationship	%
Address		Email Address		

Last Name	First Name	Middle Name		
Date of Birth	Social Security Number	Phone	Relationship	%
Address		Email Address		

(Beneficiary section continued on next page)

Underwritten by:

Individual Assurance Company, Life, Health & Accident

3200 E. Memorial Road, Suite 100, Edmond, OK 73013

(Beneficiaries Continued)

Last Name	First Name	Middle Name	
Date of Birth	Social Security Number	Phone	Relationship
Address		Email Address	%

Last Name	First Name	Middle Name	
Date of Birth	Social Security Number	Phone	Relationship
Address		Email Address	%

OPTIONAL DEPENDENT TERM LIFE INSURANCE

Available to Active Employees Only

☐ I elect Dependent Term Life Insurance.

Choose one of the following Options:	☐ 1	☐ 2	☐ 3	☐ 4
Biweekly Premium:	$3.30	$5.45	$8.55	$24.50
Coverage on Spouse:	$6,000	$10,000	$10,000	$10,000
Coverage on Children 15 days – 18 years: (thru age 24 if a full-time student)	$2,000	$3,000	$6,000	$6,000
Coverage on Parents/Parents-in-Law:	None	None	None	$3,000

List all dependents below. If additional space is needed, include all requested information for each additional dependent on a separate sheet and attach it to this Enrollment Form. Check this box ☐ if including a separate sheet with additional dependent information.

Name (last, first, middle)	Date of Birth	Social Security Number	Relationship

Option 4 only: You may insure up to two parents and up to two parents-in-law. Active Employees and/or retirees enrolled for coverage under the Marshall Islands Group Insurance Program are not eligible to be covered as dependent parents.

Relationship	Last Name	First Name	Middle Name
Father			
Mother			
Father-in-Law			
Mother-in-Law			

The Employee is the beneficiary of Dependent Life Insurance benefits.

☐ I do NOT want the optional Dependent Term Life Insurance coverage. I understand that I will have NO Dependent Term Life Insurance coverage, and if I apply at a later date, I will be required to furnish evidence of insurability.

INSURANCE AUTHORIZATION

By signing below, I declare that the above statements and answers on both pages of this Enrollment Form are complete and true to the best of my knowledge and belief. I understand that if I apply for coverage more than 61 days from my employment date or retirement date, I will be required to furnish evidence of insurability for all individuals for whom coverage is requested. Coverage is not effective until approved by Individual Assurance Company and the initial premium is paid to Individual Assurance Company. I authorize my employer to deduct from my earnings the required cost of the coverage(s) I have elected above.

Signature: _____ Date: _____

EMPLOYER MUST COMPLETE

Annual Salary: $_____ Basic Life Coverage: $_____ Premium Deduction: $_____ Process Date: _____