SYMETRA
RETIREMENT | BENEFITS | LIFE

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135

Mailing Address: Select Benefit Administrators
PO Box 674419, Houston TX 77267-4419
Phone 1-800-497-3699 | Fax (715) 682-5919

ENROLLMENT/CHANGE REQUEST

For Select Benefits Group Insurance

Group Information (To be Completed by Employer)

Group name: Woods Services, Inc.

Group number: 12676000

Effective date for action requested:

☐ Newly-Eligible Request ☐ Subsequent Enrollment Period ☐ Special Enrollment Request

Reason_____

Your Information (To be completed by individual requesting coverage)

Name | Social Security number

Date of birth | Date of hire | Gender ☐ M ☐ F | Home phone | Work phone

Job title / occupation | I am actively working ☐ Yes ☐ No | Average number of hours worked per week

Home address | City | State | Zip

Email address

Marital Status
☐ Single ☐ Married ☐ Divorced
☐ Legally Separated ☐ Separated ☐ Widowed
☐ Domestic Partner ☐ Civil Union ☐ Common Law

Action Requested

☐ Enroll in the coverage for insurance as selected below.
☐ Change (add, increase, decrease, terminate) my current coverage, as shown below.
☐ Update information about me, my dependents and/or beneficiaries.
☐ Terminate all current coverage.

Coverage

Fixed-Payment Medical

Option Option 1 _____ Option 2 _____
Identify coverage option

☐ Self
☐ Self plus spouse
☐ Self plus child(ren)
☐ Self plus family
☐ Decline

Accident

Option Plan 1
Identify coverage option

☐ Self
☐ Self plus spouse
☐ Self plus child(ren)
☐ Self plus family
☐ Decline

Critical Illness*

Option:

Employee Amount ___________($5000, $15000, $20000, $25000 or $30,000)

Spouse Amount __________ ($2500, $5000 or $15000)

Child Amount __________ ($2,500 or $5,000)

(Indicate current amount)

☐ Self
☐ Self plus spouse
☐ Self plus child(ren)
☐ Self plus family
☐ Decline

Have you used nicotine in the past 12 months?
☐ Yes ☐ No

** Evidence of insurability may be required*

Dependent Information

(Complete to add, change or terminate coverage for dependents. List additional dependents on a separate sheet and attach to this form.)

No person can be insured under any policy as both a certificate holder and a dependent, or as a dependent of more than one certificate holder. The effective date of coverage for a dependent who is confined may be delayed.

Name

Date of birth	Gender	Full-time student	Relationship
	☐ M ☐ F	☐ Yes ☐ No	

Home address (if different than your address) | City | State | Zip

☐ Add
☐ Change
☐ Terminate

Coverage: ☐ Fixed-Payment Medical ☐ Accident ☐ Critical Illness

Name

Date of birth	Gender	Full-time student	Relationship
	☐ M ☐ F	☐ Yes ☐ No	

Home address (if different than your address) | City | State | Zip

☐ Add
☐ Change
☐ Terminate

Coverage: ☐ Fixed-Payment Medical ☐ Accident ☐ Critical Illness

Name

Date of birth	Gender	Full-time student	Relationship
	☐ M ☐ F	☐ Yes ☐ No	

Home address (if different than your address) | City | State | Zip

☐ Add
☐ Change
☐ Terminate

Coverage: ☐ Fixed-Payment Medical ☐ Accident ☐ Critical Illness

Signatures

*(Sign and date **only one option** below. Retain a copy for yourself. Provide the original to your insured group's representative.)*

Authorization

(If you are enrolling in, changing or updating coverage)

☐ I, the undersigned, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy (or policies) insured by Symetra Life Insurance Company. I authorize the deduction from my earnings for any contribution I am required to make toward the cost of this insurance. I further understand that I may not be able to make any changes to my elected coverage until the next enrollment period.

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

This form replaces all Enrollment/Change Request forms previously submitted.

Enrollee/Employee signature	Date

Waiver *(If you are declining or terminating all coverage.)*

☐ I, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 30 days of the date I am first eligible, that I may have to wait to obtain coverage until the next enrollment period.

Further, I understand that I may not be able to obtain coverage for benefits in the future without submitting satisfactory evidence of insurability 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.

Reason: ☐ I already have insurance ☐ Other_____

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

This form replaces all Enrollment/Change Request forms previously submitted.

Enrollee/Employee signature	Date