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CONTRACT NUMBER:

GROUP NUMBER:

24-HOUR ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE APPLICATION

EMPLOYEE SOC. SEC. NO.: _____ EMPLOYEE NAME: _____ BIRTH DATE: _____
First Middle Last
 ADDRESS: _____ HOME PHONE: () _____ WORK PHONE: () _____

APPLICATION FOR COVERAGE

I WOULD LIKE TO ENROLL IN THE 24-HOUR ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE PROGRAM. I AGREE TO PAY THE ENTIRE PREMIUM.

REQUESTED COVERAGE: (Check one)

- Employee only
- Employee with Spouse and Children
- Employee and Spouse Only (No Children)
- Employee and Children Only (No Spouse)

REQUESTED EMPLOYEE COVERAGE:

- \$ 20,000 \$ 80,000 \$ 160,000
- \$ 30,000 \$ 100,000 \$ 180,000
- \$ 40,000 \$ 120,000 \$ 200,000
- \$ 60,000 \$ 140,000 \$ 300,000 \$ 400,000

Complete the following information in full. Failure to list all eligible dependents or to add new dependents will result in no coverage for the omitted person. List yourself and all legal dependents. Attach a separate sheet if necessary.

NAME OF FAMILY MEMBER (FIRST, MIDDLE INITIAL, LAST)	BIRTH DATE			RELATIONSHIP TO EMPLOYEE	SEX
	MO	DAY	YR		
EMPLOYEE				SELF	
SPOUSE				SPOUSE	

IT IS MUTUALLY AGREED THAT:

- (a) THE REPRESENTATIONS IN THIS APPLICATION ARE CORRECTLY RECORDED, COMPLETE, AND TRUE TO THE BEST KNOWLEDGE OF THE UNDERSIGNED;
- (b) VOLUNTARY CHANGE IN THE INSURANCE COVERAGE REQUIRES AGREEMENT BETWEEN THE EMPLOYEE AND DESERET HEALTHCARE;
- (c) NO REPRESENTATIVE OF ANY PARTICIPATING EMPLOYER (EXCEPT DESERET HEALTHCARE) IS AUTHORIZED TO ACCEPT RISKS, PASS UPON INSURABILITY, OR WAIVE ANY OF DESERET HEALTHCARE'S RIGHTS OR REQUIREMENTS;
- (d) NO INSURANCE APPLIED FOR HEREIN SHALL GO INTO FORCE OR TAKE EFFECT UNLESS AND UNTIL IT HAS BEEN ACCEPTED BY DESERET HEALTHCARE AND THE FIRST PREMIUM HAS BEEN COLLECTED DURING THE GOOD HEALTH OF THE PERSON(S) TO BE COVERED; AND
- (e) THE INSURANCE APPLIED FOR HEREIN, IF APPROVED, SHALL TERMINATE UPON FAILURE TO PAY THE PREMIUMS OR AS PROVIDED FOR IN THE PLAN.

I AUTHORIZE MY EMPLOYER, UNTIL THIS AUTHORIZATION IS REVOKED BY ME IN WRITING, TO DEDUCT FROM ANY EARNINGS DUE ME THE AMOUNT NECESSARY FOR PREMIUMS DUE DESERET HEALTHCARE FOR INSURANCE PROTECTION INDICATED ON THIS APPLICATION.

DATE _____ SIGNED _____

BENEFICIARY INFORMATION

To name the needed primary and alternate beneficiaries for 24-Hour Accidental Death & Dismemberment Insurance, please complete the *Basic and Supplemental Plans Beneficiary Form*.

WAIVER OF 24-HOUR ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

- I DO NOT WISH TO ENROLL AT THIS TIME.
- I WISH TO DISCONTINUE MY 24-HOUR ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE.

I HEREBY ACKNOWLEDGE THAT I HAVE BEEN GIVEN AN OPPORTUNITY TO APPLY FOR THE 24-HOUR ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE AS OFFERED BY MY EMPLOYER, AND AFTER CAREFUL CONSIDERATION, I HAVE DECIDED NOT TO TAKE ADVANTAGE OF THIS OFFER AT THIS TIME. I UNDERSTAND THAT I MAY ENROLL FOR COVERAGE AT A LATER TIME.

DATE _____ SIGNED _____
 TO BE SIGNED ONLY IF BENEFITS ARE REJECTED.

FOR EMPLOYER'S USE ONLY

- NEW HIRE
- CHANGE
- OTHER _____

EFFECTIVE DATE OF CHANGE _____

Complete the following:

AMOUNT OF COVERAGE _____ MONTHLY PREMIUM _____

- DISCONTINUING PREVIOUS COVERAGE AS OF _____

Company _____ Employer Authorization _____ Date Signed _____

FOR DESERET HEALTHCARE USE ONLY

COMMENTS: _____

EFFECTIVE DATE: _____ INITIALS: _____