DMBA
150 Social Hall Avenue, Suite 170
P.O. Box 45530 • Salt Lake City, Utah 84145
Telephone: 801-578-5600 • Toll free: 800-777-3622
Fax: 801-578-5933 • Website: www.dmba.com

24-HOUR ACCIDENTAL DEATH & DISMEMBERMENT APPLICATION

PLEASE COMPLETE EACH SECTION IN FULL

APPLICATION FOR BENEFITS

Employee name: _____

DMBA ID number: _____

Employer name: _____ Department: _____

Home address: _____

Home phone:_____ Work phone: _____

I wish to enroll in 24-Hour Accidental Death & Dismemberment. I agree to pay the entire premium. I request to enroll in benefits as follows (check one plan and one benefit level):

Benefit Plan	Benefit Level		
❑ Single plan (employee only)	❑ $20,000	❑ $80,000	❑ $160,000
❑ Family plan with children	❑ $30,000	❑ $100,000	❑ $180,000
❑ Family plan without children	❑ $40,000	❑ $120,000	❑ $200,000
❑ Family plan without spouse	❑ $60,000	❑ $140,000	❑ $300,000
			❑ $400,000

ENROLLMENT INFORMATION

Complete the following information in full. If you don't list all eligible dependents or add new dependents, those persons will not be enrolled. List yourself and all legal dependents. Attach a separate sheet if necessary.

APPLICANT NAME (FIRST, MIDDLE, LAST)	RELATIONSHIP TO EMPLOYEE	BIRTH DATE (MM/DD/YYYY)	SEX
EMPLOYEE	SELF		
	SPOUSE		

CONTINUED ON THE BACK OF THIS PAGE

AUTHORIZATION

IT IS MUTUALLY AGREED THAT:

- The representations in this application are correctly recorded, complete, and true to the best knowledge and belief of the undersigned.
- Voluntary change to this benefit requires agreement between the employee and DMBA.
- No representative of any participating employer (except DMBA) is authorized to accept risks, pass upon eligibility, or waive any plan rights or requirements.
- The benefit applied for herein shall not go into force or take effect unless and until the application has been approved and the first premium has been collected during the good health of the person(s) to be enrolled.
- The benefit applied for herein, if approved, shall end upon failure to pay the premiums or as provided for in the plan.

Signature: _____ Date: _____

BENEFICIARY INFORMATION

To designate your beneficiaries, complete a *Beneficiary Form* or log onto www.dmba.com.

WAIVER OF BENEFIT

❑ I do not wish to enroll at this time.

❑ I wish to discontinue participation in 24-Hour Accidental Death & Dismemberment.

I hereby acknowledge I have been given an opportunity to apply for 24-Hour Accidental Death & Dismemberment as offered by my employer and, after careful consideration, I have decided not to take advantage of this offer. I understand I may enroll at a later time.

Signature: _____ Date: _____

SIGN ONLY IF BENEFITS ARE REJECTED