SISC III
SELF-INSURED SCHOOLS OF CALIFORNIA
Schools Helping Schools

Basic Life /AD&D Insurance
Enrollment Form

EMPLOYEE SECTION (Please print clearly. Required fields are marked with an asterisk (*).)

SOCIAL SECURITY NO.	LAST NAME (PRINT)	FIRST NAME (PRINT)			MI	GENDER ☐ MALE ☐ FEMALE
DATE OF BIRTH	STREET ADDRESS	CITY	STATE	ZIP	☐ FULL-TIME ☐ PART-TIME	

BENEFICIARY FOR DEATH BENEFITS (Right to change beneficiary is reserved to the insured.)

If more than one beneficiary is named, the beneficiaries shall share benefit equally unless otherwise stated below. If indicating benefit percentages, the percentages must total 100% for Primary Beneficiaries and 100% for Secondary Beneficiaries. Some states have laws regarding beneficiary designation. Please consult your employer/benefits administrator for additional information.

Primary Beneficiary Designation

LAST NAME	FIRST NAME	RELATIONSHIP (Spouse, Child, etc.)	DATE OF BIRTH (MM/DD/YYYY)	ADDRESS OF BENEFICIARY (Address, City, State, Zip)	BENEFIT PERCENTAGE
				Percentage Total:	100%

Secondary Beneficiary Designation

LAST NAME	FIRST NAME	RELATIONSHIP (Spouse, Child, etc.)	DATE OF BIRTH (MM/DD/YYYY)	ADDRESS OF BENEFICIARY (Address, City, State, Zip)	BENEFIT PERCENTAGE
				Percentage Total:	100%

ENROLLMENT INFORMATION

Enrollment must occur within 31 days from the date the employee becomes eligible (or as otherwise stated in the policy). If you are required to pay premiums for any coverage, the enrollment form must be signed and dated to authorize payroll deductions. The premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the policy as well as your salary and age on the effective date of the policy.

AGREEMENT AND SIGNATURE

I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not ensure my eligibility for coverage. I understand and agree that I must satisfy all active work and/or active employment requirements that pertain to the policy to be eligible for coverage. I understand and agree that life insurance coverage for my eligible dependents may be delayed if they are confined (at home, in a hospital, or in any other institution or facility) or disabled on the date insurance would otherwise begin, in accordance with the terms of the policy. Should I decline coverage(s), I understand and accept the Waiver of Group Insurance provisions that follow.
By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summaries provided to me for each line of coverage. I understand that payment of premium does not ensure eligibility for coverage.

SIGNATURE OF EMPLOYEE _____ **DATE** _____/_____/_____

WAIVER OF GROUP INSURANCE

Should I apply for waived coverage(s) in the future (either for myself or my eligible dependent(s)), I understand that evidence of insurability may be required, acceptable to the Insurance Company, at my own expense.
The above requirements will apply unless otherwise stated in the policy, or unless prohibited by any applicable state or federal law.

DISTRICT USE ONLY

DISTRICT NAME:			DISTRICT ID #:	
HIRE DATE:	EFFECTIVE DATE:	HOURS WORKED PER WEEK:	OCCUPATION:	AMOUNT OF COVERAGE:

Original/District Copy/SISC Copy/Employee