2022 OPEN ENROLLMENT FORMS

- BENEFIT ELECTION WORKSHEET
- MEDICAL ENROLLMENT/CHANGE FORM
- DENTAL ENROLLMENT/CHANGES FORM
- VISION ENROLLMENT/CHANGE FORM
- GROUP LIFE & DEPENDENT LIFE APPLICATION
- GROUP LIFE BENEFICIARY DESIGNATION FORM

AssuredPartners

4582 S. ULSTER STREET, SUITE 600, DENVER, CO 80237
PHONE: 303-863-7788

BENEFITS ENROLLMENT/CHANGE WORKSHEET

2022 Plan Year | January 1 - December 31, 2022

AssuredPartners

4582 S Ulster St Suite 600 Denver CO 80237

IMPORTANT: Your enrollment worksheet and any applicable carrier forms must be returned to the HR Office within 30 days of eligibility. Failure to submit elections within the 30-day deadline may result in no insurance coverage for the entire plan year.

PLEASE PRINT LEGIBLY -- INCOMPLETE INFORMATION WILL RESULT IN THE DELAYED PROCESSING OF YOUR ENROLLMENT SELECTIONS

EMPLOYEE DATA

Social Security #	Date of Birth *(mm/dd/yyyy)*	Date of Hire *(mm/dd/yyyy)*	Gender ☐ Male ☐ Female	Relationship Status ☐ Single ☐ Married
Name *(Last, First, MI)*				
Mailing Address				
City, State, Zip			Telephone Number	

DEPENDENT INFORMATION *(list all eligible dependents you want covered) Use back of sheet if you have additional dependents*

Name *(Last, First, MI)*	Date of Birth (mm/dd/yyyy)	Social Security #	Gender	Relationship	Coverage Desired
			☐ Male ☐ Female	☐ Spouse ☐ Child	☐ Medical ☐ Vision ☐ Dental
Name ***(Last, First, MI)***	Date of Birth (mm/dd/yyyy)	Social Security #	☐ Male ☐ Female	☐ Spouse ☐ Child	☐ Medical ☐ Vision ☐ Dental
Name ***(Last, First, MI)***	Date of Birth (mm/dd/yyyy)	Social Security #	☐ Male ☐ Female	☐ Spouse ☐ Child	☐ Medical ☐ Vision ☐ Dental
Name ***(Last, First, MI)***	Date of Birth (mm/dd/yyyy)	Social Security #	☐ Male ☐ Female	☐ Spouse ☐ Child	☐ Medical ☐ Vision ☐ Dental

CIRCLE COVERAGE TYPE (single, family, etc,) and the DEDUCTION (cost) for each benefit.

PER PAY PERIOD DEDUCTIONS (24 PAY PERIODS)

Benefit Plan	EMP ONLY	EMP+SPOUSE	EMP+CHILD(REN)	EE+FAMILY	PER CHECK COST (*please mark "W" if waiving*)
Plan 1 - Anthem / No GAP	$ 3.56	$ 293.17	$ 195.44	$ 540.73	
Plan 2 - Anthem / $8K GAP	$ 51.07	$ 391.71	$ 277.53	$ 667.00	
The Standard Vision	$ 3.56	$ 4.81	$ 5.56	$ 9.12	
Delta Dental	$ 12.62	$ 26.05	$ 33.86	$ 50.55	
Dependent Life $5k SP/$5k CH	$ N/A	$ 1.03	$ 1.03	$ 1.03	

TOTAL PRE-TAX DEDUCTIONS ***(total per pay period cost of your benefit selections)*** **$**

NOTE: These elections are irrevocable during the plan year except for qualified changes in status as defined by the IRS.

REASON FOR ENROLLMENT *(check one)*

☐ New Enrollment

☐ Open Enrollment

☐ Other _____

☐ Coverage change (*please check applicable box below*)

☐ Add Dependent(s)

☐ Delete Dependent(s)

☐ Loss of Coverage

☐ Gain Other Group Coverage

Reason:_____ *(i.e. marriage, divorce, death, birth/adoption of child)*

Date of Event _____/_____/_____

☐ Waiver of Coverage

I have been offered the above coverage and I elect to waive all participation for myself and my eligible dependents.

EMPLOYEE CERTIFICATION

I understand that all benefits for me and my eligible dependents will be provided in accordance to the terms of the plan(s) in which I have enrolled. I authorize my employer to reduce my salary by the amount necessary to pay for my benefit elections.

Employee Signature_____ Date _____/_____/_____ Effective Date of Coverage: _____/_____/_____

Enrollment Application and Change Form
Medical, Dental, Vision

Anthem BlueCross BlueShield

Check all coverage that applies: ☐ Medical

Social Security no.[1] (required) (must be completed by employee)	Member no. (must be completed by employee)	Employer case no. (must be completed by employer)		

SECTION 1: REASON FOR COMPLETING APPLICATION

☐ New enrollment ☐ Beneficiary change ☐ Reinstatement of coverage ☐ Coverage change ☐ PCP change ☐ Canceling coverage
☐ Personal information change ☐ Other: _____

☐ Qualifying event (See sections 8, 9 and 10 for requirements on qualifying events/special enrollments.) | Effective date of change

SECTION 2: BENEFITS AND COVERAGE DESIRED

Ask your employer for coverage available. For life and disability insurance, see page 5. Ask your employer if dependent coverage for designated beneficiary (DB)[2] or domestic partner (DP)[3] is offered under your selected plan.

MEDICAL BENEFIT PLAN	MEDICAL COVERAGE				
☐ PPO – BlueClassic ☐ EPO – Pathway ☐ Other: _____	☐ Employee ☐ Employee & spouse/DB/DP ☐ Employee & child(ren) ☐ Family ☐ Decline & complete waiver (section 6)				

SECTION 3: EMPLOYEE AND FAMILY INFORMATION

List yourself and all eligible family members who are applying for or waiving coverage. Include information on designated beneficiary or domestic partner only if coverage for designated beneficiary or domestic partner is offered by your employer. Use a separate sheet, if needed.

☐ Add ☐ Change ☐ Cancel ☐ Waive	Employee last name	First name	M.I.	Gender ☐ Male ☐ Female	Date of birth (MM/DD/YYYY)	Relationship **Self**
Mailing street address for member correspondence		City	State	ZIP code	Email address	
Home phone no.	Date of hire (MM/DD/YYYY)	Date of full-time employment	☐ Hourly ☐ Salaried	Hours worked/week	Earnings: $ _____ Per: _____	
Full company name		Position title	Primary care physician (PCP) – HMO or Blue Priority[4]	PCP ID no.	Current patient ☐ Yes ☐ No	

☐ Add ☐ Change ☐ Cancel ☐ Waive	Spouse/designated beneficiary/domestic partner last name	First name	M.I.	Gender ☐ Male ☐ Female	Date of birth (MM/DD/YYYY)
Primary care physician (PCP)[4]	PCP ID no.	Current patient ☐ Yes ☐ No	Relationship ☐ Spouse/Statutory Marriage (If Special Enrollment, attach Marriage Certificate) ☐ Common-Law Marriage (Complete section 8) ☐ Domestic Partner (Complete section 9) ☐ Civil Union (If Special Enrollment, attach Civil Union Registration) ☐ Designated Beneficiary (Attach Recorded Designated Beneficiary Agreement)		Social Security no.[1] (required)

☐ Add ☐ Change ☐ Cancel ☐ Waive	Dependent last name	First name	M.I.	Gender ☐ Male ☐ Female	Date of birth (MM/DD/YYYY)	Relationship
Primary care physician (PCP)[4]	PCP ID no.	Current patient ☐ Yes ☐ No	☐ Over-age mentally/physically disabled dependent (**Initial Over-age Dependent Affidavit in section 7**, and attach *Mentally/Physically Disabled Dependent Form.*) ☐ Court-ordered health care coverage (attach copy of court order.)		Social Security no.[1] (required)	

☐ Add ☐ Change ☐ Cancel ☐ Waive	Dependent last name	First name	M.I.	Gender ☐ Male ☐ Female	Date of birth (MM/DD/YYYY)	Relationship
Primary care physician (PCP)[4]	PCP ID no.	Current patient ☐ Yes ☐ No	☐ Over-age mentally/physically disabled dependent (**Initial Over-age Dependent Affidavit in section 7**, and attach *Mentally/Physically Disabled Dependent Form.*) ☐ Court-ordered health care coverage (attach copy of court order.)		Social Security no.[1] (required)	

1 Anthem is required by the Internal Revenue Service to collect this information.
2 A person named as Designated Beneficiary (DB) under a Recorded Designated Beneficiary Agreement.
3 A person named as Domestic Partner (DP) under a Certificate of Registered Domestic Partnership.
4 For HMO and Blue Priority members: If you do not select a PCP, one may be assigned to you.
5 Confirm with your employer which HSA custodian was selected.

Required: Employee Social Security/member no.:

SECTION 3: EMPLOYEE AND FAMILY INFORMATION — Continued.

☐ Add ☐ Change ☐ Cancel ☐ Waive	Dependent last name	First name	M.I.	Gender ☐ Male ☐ Female	Date of birth (MM/DD/YYYY)	Relationship

Primary care physician (PCP)[1]	PCP ID no.	Current patient ☐ Yes ☐ No	☐ Over-age mentally/physically disabled dependent (**Initial Over-age Dependent Affidavit in section 7**, and attach *Mentally/Physically Disabled Dependent Form.*) ☐ Court-ordered health care coverage (attach copy of court order.)	Social Security no.[2] (required)

1 For HMO and Blue Priority members: If you do not select a PCP, one may be assigned to you.

2 Anthem is required by the Internal Revenue Service to collect this information.

SECTION 4: OTHER INSURANCE

Have you or any of your dependents had any other health coverage in the last six months, or currently have coverage other than the applied-for coverage? ☐ Yes ☐ No
If Yes, please complete the section below for all covered members.

Member name (first, middle initial, last)	Type	Carrier	Start (MM/DD/YYYY)	End (MM/DD/YYYY)
	☐ Medical ☐ Dental ☐ Vision ☐ Prescription			
	☐ Medical ☐ Dental ☐ Vision ☐ Prescription			

SECTION 5: MEDICARE COVERAGE — Complete if you, your spouse/domestic partner or dependent child(ren) have Medicare coverage. Use a separate sheet, if needed.

Member name (first, middle initial, last)	Part A effective date	Part B effective date	Reason for disability if under age 65	Medicare claim no.

SECTION 6: WAIVER OF INSURANCE — Complete only if you intend to waive insurance.

I hereby certify that I have been given the opportunity to participate in my employer's group insurance plan(s) underwritten by the company(ies) indicated on this *Enrollment Application*. The plan has been explained to me, and I decline to participate. **I do not want to participate in the group insurance plan for the following reason(s)** (Check all that apply):

☐ I have other group health insurance.
☐ I have other group dental insurance.
☐ I am a dependent of an active or retired military service member.
☐ I am retired from military service.
☐ I do not wish to participate (contributory life insurance).
☐ I have other individual health insurance.
☐ I have other group vision insurance.
☐ I have no other insurance coverage, and I am not interested at this time.
☐ I have religious objections (non-contributory life insurance).
☐ I and/or my dependent(s) have coverage under a state child health insurance program or a state Medicaid plan.

SECTION 7: OVER-AGE DEPENDENT AFFIDAVIT

By initialing below, I verify and attest that my dependent(s), age 26 and over, is/are unmarried and financially or otherwise dependent on me due to mental and/or physical disability; and therefore eligible for coverage under the policy for which I am applying. I understand that I am responsible for notifying Anthem within 31 days of any changes to the status of my dependent(s). I understand that coverage is dictated by the actual situation at the time services are rendered, and if my dependent does not qualify as a dependent when services are provided, the charges for those services are not reimbursable by Anthem and may become my sole responsibility. I also understand that over-age dependent eligibility must be renewed each year as specified by the certificate. I understand that Anthem reserves the right to request, at any time, proof of over-age dependency.

Initials: _____

SECTION 8: COMMON-LAW AFFIDAVIT — Signatures required.

We the undersigned, being of lawful age, attest to the following facts:

- We have lived together continuously, in Colorado, as husband and wife from _____ to the present.
- We are free to contract a valid ceremonial marriage, i.e., are not already married to someone else.
- We hold ourselves out as husband and wife, consent to the marriage, cohabit and have the reputation in the community as being husband and wife.
- We understand that a common-law marriage, in the state of Colorado, is valid for all purposes, the same as a ceremonial marriage, and can only be terminated by death or divorce.

Employee signature	Spouse signature	Date (MM/DD/YYYY)
X	**X**	

Required: Employee Social Security/member no.:

SECTION 9: DOMESTIC PARTNER AFFIDAVIT — Signatures required.

We depose and attest to the following:

1. We are both at least eighteen (18) years of age and we are mentally competent to contract.
2. Neither of us is legally married to another person, nor is either of us a member of another domestic partnership.
3. We are sole Domestic Partners and have been sole Domestic Partners for at least twelve (12) months preceding the date of this Affidavit. We have been sole Domestic Partners living together continuously since _____ (month/day/year), and we intend to remain sole Domestic Partners indefinitely.
4. We are neither related by blood closer than permitted by state law for marriage.
5. We are jointly responsible for each other's common welfare as evidenced through, for example, a joint deed, joint mortgage, joint lease, joint credit card, joint bank account, designation of Domestic Partner as beneficiary for a life insurance or retirement contract, designation of Domestic Partner as primary beneficiary in the Employee's will, and/or powers of attorney authorizing each of us to act on behalf of the other.
6. We understand that a Domestic Partner enrolled as a dependent ceases to be an eligible member on the first day of the month following the termination of such domestic partnership and that the Employee is required to submit an *Enrollment Application and Change Form* within 31 days of the termination of the domestic partnership or within the time specified in the Employee's certificate.

Employee signature **X**	Domestic partner signature **X**	Date (MM/DD/YYYY)

SECTION 10: SIGNATURE — Required.

I understand that the coverage I am applying for is subject to eligibility requirements. I acknowledge that I have read all sections of this application, including the information on the back page, and certify that I agree to all matters covered herein. I also acknowledge that all information provided on this application is complete and accurate to the best of my knowledge. I understand and agree that this application shall become part of the contract between Anthem and me.

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Description of Special Enrollments

If you decline enrollment for yourself or your dependents (including your spouse/designated beneficiary/domestic partner) because of other health insurance or group health plan coverage except coverage under a state child health insurance program or a state Medicaid plan, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 31 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you decline enrollment for yourself or your dependents (including your spouse/designated beneficiary/domestic partner) because of coverage under a state child health insurance program, you may be able to enroll yourself and your dependent(s) in this plan if you or your dependent(s) lose eligibility under the state child health insurance program. However, you must request enrollment within 90 days after the date the coverage under a state child health insurance program ends.

If you decline health coverage for yourself or your dependent(s) (including your spouse/designated beneficiary/domestic partner) because of coverage under a state Medicaid plan, you may be able to enroll yourself and your dependents in this plan if you or your dependent(s) lose eligibility under a state Medicaid plan. However, you must request enrollment within 60 days after the date the coverage under a state Medicaid plan ends.

If you become eligible for state premium assistance for group coverage, you may be able to enroll yourself and your dependent(s) (including your spouse/designated beneficiary/domestic partner) in this plan. However, you must request enrollment within 60 days after the date you become eligible for state premium assistance for group coverage.

In addition, if you have a new dependent as a result of marriage/Signed Common-Law Certificate/Civil Union Registration/Recorded Designated Beneficiary Agreement/Certificate of Domestic Partnership, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage/Recorded Designated Beneficiary Agreement/Certificate of Domestic Partnership, birth, adoption or placement for adoption.

In addition, a person may be entitled to a special enrollment pursuant to a qualified medical child support order or other court or administrative order mandating that the individual be covered.

If enrolling due to special enrollment, Anthem will request legal proof of actual qualifying event. Such documents may include, but are not limited to, court orders, marriage certificates, civil union registrations, and designated beneficiary agreements. For common law and domestic partner coverage, please fill out sections 8 and 9.

To request special enrollment, submit a completed application to the address below. To obtain more information, contact Anthem Customer Service at 1-877-811-3106 or Anthem Blue Cross and Blue Shield, P.O. Box 5858, Denver, CO 80217-5858.

Employee signature **X**	Date (MM/DD/YYYY)

MERP Administration Services Inc.

DIRECT DEPOSIT AUTHORIZATION FORM

For employee to receive benefit payments electronically.

Payer Information:

Name: MERP Administration Services, Inc.
Address: P.O. Box 4826
Greenwood Village, CO 80155

Phone Number: 303-872-2044
Fax Number: 1-888-551-8357

Name of Your Employer:

Conejos County

Payee Information:

Name on Account:

Address:

Street

City, State, ZIP

Phone Numbers:
Home:
Mobile:

Financial Institution:

Name:
Address:
(City, State)

Phone Number:
Bank Routing Number:
Account Number:

Type of Account: Checking Savings

☐ I authorize MERP Administration Services, Inc. to deposit all payments due to me in the account(s) named herein. I further authorize MERP Administration Services, Inc. the authority to make debits or take other corrective actions, if necessary, in relation to any deposit made by EZMERP.

☐ I do not wish to have electronic payment of benefits. I realize this will result in benefit payments being made by check and sent via regular USPS mail. It is my responsibility to ensure that EZMERP has my correct street address.

MERP Administration Services, Inc.

Signed:

Dated:

Submit form via fax (888-5518357) or email to: gmb@merpclaims.com, or USPS to PO Box

DELTA DENTAL®

Enrollment Form

Applicant: Select an insurance plan or Patient Direct discount plan (below).

❑ Delta Dental Premier®
❑ Delta Dental PPO™
❑ Delta Dental PPO™ Plus Premier
❑ Exclusive Panel Option (EPO)
❑ Delta Dental MAC PPO™

❑ Delta Dental Patient Direct® (for Patient Direct, the following fields are mandatory):

1. Patient Direct Provider Name: _____

2. Patient Direct Provider Number: _____

❑ New Enrollment ❑ Waive Coverage ❑ Change Coverage | ❑ Active ❑ Retired ❑ COBRA/State Continuation

Employee Information (please print clearly or type). All fields are required.

Employer:		Group #:	Subgroup #:
SSN:	Date of Birth:	Date of Hire:	Effective Date:
Last Name:		First Name:	❑ M / ❑ F
Street Address:		City:	State: Zip:
Email Address:			Cell Phone:

Would you like to receive communications from Delta Dental of Colorado by email and text message? ❑ Yes ❑ No
Your email address and cell phone will not be used for any purpose other than communications from Delta Dental of Colorado.

Select Coverage: ❑ Employee Only ❑ Employee and Spouse ❑ Employee and Children ❑ Employee, Spouse, and Children

Please list all dependents. All fields are required.

Add	Delete	Last Name	First Name	SSN	Date of Birth	M	F
❑	❑					❑	❑
❑	❑					❑	❑
❑	❑					❑	❑
❑	❑					❑	❑
❑	❑					❑	❑

If you need more space to list additional dependents, please use a second enrollment form.

Changes to Existing Eligibility

Date change is effective (mm/dd/yyyy):

Reason for change/explanation:	List effective date for checked boxes below.	
❑ Name Change (list above)	❑ Marriage	Date: _____
❑ Cancel Coverage	❑ Birth/Adoption*	Date: _____
❑ Employment Terminated	❑ Divorce	Date: _____
❑ Reinstatement of Coverage (see reverse)	❑ Death	Date: _____
❑ Address Change (list above)	❑ No Longer Eligible	Date: _____
❑ COBRA/State Continuation (list start date above)	❑ Part-time to Full-time	Date: _____
❑ Late Enrollment (if applicable)	❑ Retiree	Date: _____
❑ Family Status Change	❑ Add Disabled Child*	Date: _____
❑ Add Dependent ❑ Delete Dependent	❑ Transfer to Group/Subgroup: _____	Date: _____
❑ Other Reason for Change: _____		

I understand that the terms of the contract between Delta Dental and my company may not allow for late enrollment for my dependents. The contract may allow for late enrollments but may require waiting periods or additional limitations.

Employee's Signature **Date**

It is unlawful to knowingly provide false, incomplete, or misleading information to Delta Dental of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Report any insurance company or agent thereof, who knowingly provides false, incomplete, or misleading facts to Delta Dental participants for the purpose of defrauding the participants regarding their insurance benefits, to the Colorado Division of Insurance.

Delta Dental of Colorado
PO Box 5468
Denver, CO 80217-5468

Phone: 303-741-9300, ext. 3900
Toll-free: 1-800-233-0860, ext. 3900

Standard Insurance Company

Vision **Enrollment and Change**

To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
166780			

To Be Completed By Applicant

☐ Apply for Coverage ☐ Name Change Former Name _____

☐ Add Dependent ☐ Delete Dependent Date of Add/Delete _____

Your Full Name	Social Security Number	Birth Date	
Address	City	State	ZIP
Phone Number	Job Title/Occupation	☐ Male ☐ Female	
Employer Name **Conejos County**	Hours Worked Per Week		

Coverage

Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, Evidence Of Insurability requirements.

Eye Care Insurance

☐ Balanced Eye Care (Employee Paid)

Are you or your dependents covered for eye care insurance under another plan? ☐ Yes ☐ No

List Dependents to enroll or drop for Eye Care, if applicable. (Attach sheet for additional dependents, if needed.)

Full Name (Last name if different, First, Middle Initial)	Eye Care (Employee paid)		Gender		Date of Birth
	Add	Drop	M	F	
Spouse	☐	☐	☐	☐	
Child 1	☐	☐	☐	☐	
Child 2	☐	☐	☐	☐	
Child 3	☐	☐	☐	☐	

Eye Care Insurance Waiver: Contributory Eye Care Insurance

The insurance coverage available to me and my Dependents has been explained to me and I do not want to enroll at this time. I understand that if I elect to enroll in the future, the insurance coverage may be subject to a Late Entrant Penalty.

I decline ☐ Eye Care insurance for myself.

I decline ☐ Eye Care insurance for one or more dependents.

Your Full Name

Signature

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Signature of Applicant (Member/Employee)	Date

Group Life Enrollment Form

American United Life Insurance Company®
a ONEAMERICA® *company*
One American Square, P.O. Box 6123
Indianapolis, IN 46206-6123
(800) 553-5318
www.employeebenefits.aul.com

ONEAMERICA®

Applicant's Full Legal Name:			Employment Status: ☐ Active ☐ Retired
Applicant's Social Security Number:	Date of Birth:	Marital Status: ☐ Single ☐ Married	Gender: ☐ Male ☐ Female
Applicant's State of Residence:	Applicant's Residential Zip Code:	Employer: County of Conejos	
Applicant's Telephone Number: (normal business hours): ( ) -	Applicant's E-mail Address:		Employed Full-Time: ☐ Yes ☐ No
		Are you authorized to work and reside in the US? ☐ Yes ☐ No	

COVERAGE BEING APPLIED FOR: Apply for or decline each coverage listed below. Not checking a box or boxes will be considered a declination of that coverage.

	Benefit Amount / Option Requested	
Basic Term Life & AD&D	☑ Elect	
Employee Voluntary Term Life & AD&D	☐ $_____	☐ Decline
Spouse Voluntary Term Life & AD&D	☐ $_____	☐ Decline
Child Voluntary Term Life & AD&D	Option_____ ☐ Elect	☐ Decline

*If spouse is included in dependent coverage: Name _____Date of birth _____.

NOTE: Coverage is only offered and available to eligible Dependents who are authorized to reside in the United States.

For AUL Term Life Coverages, identify your Beneficiary Designation to ensure proceeds can be paid according to your wishes.

Name of Primary Beneficiary:	Percentage:	Relationship:	SSN/Date of Birth:
Name of Contingent Beneficiary:	Percentage:	Relationship:	SSN/Date of Birth:

- I hereby apply for the requested group life and/or disability insurance coverage for which I and my dependents, if any, are eligible and available under AUL's policy. I understand receipt of any coverage greater than the guaranteed issue amount or application for coverage after the approved enrollment period first requires medical underwriting and written approval by AUL.
- I authorize my employer to deduct from my wages the amount of premium required for the amount of coverage approved by AUL, including any premium increases due to age bracket or salary changes when applicable. Premium payments greater than the amount of premium owed will not result in additional coverage under AUL's policy.
- The undersigned represents any information or documents provided to AUL by the undersigned prior to and after the date of the application for insurance and the facts and other matters contained in the foregoing are true and accurate to the best of the undersigned's knowledge and belief.

  The undersigned understands and agrees 1. any insurance coverage or benefit are contingent upon any statements made to AUL as being complete and correct and 2. benefits under any group life or disability insurance policy will be paid only if AUL or its third party administrator decides in its discretion the applicant is entitled to them. The undersigned have read, understand, and retained the notices, limitations, and exclusions for his/her records.
- Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

Signature of Applicant: _____ **Date:** _____

MUST BE COMPLETED BY THE EMPLOYER	Group Policy #:	Class # :	Employer: County of Conejos	Occupation:	Employer's State: CO	
	Salary: Mode: [ ] Hourly [ ] Weekly [ ] Bi-Weekly [ ] Semi-Monthly [ ] Monthly [ ] Annually F/T Requirements (hours, days, weeks, etc.):				Date Hired Full Time:	