SYMETRA FINANCIAL

Symetra Life Insurance Company
Redmond, WA 98052

ENROLLMENT FORM

Mail or Fax to:
Simple HR
1077 E. Hwy 98, Suite 200
Destin, FL 32541
FAX: (850) 650-9396

PART I – TO BE COMPLETED BY THE EMPLOYEE

Employee's Name (Last, First, Middle)	**Social Security #**	**Date of Birth** / /	**Case Number** 84750☐ 84760☐ 84770☐
Employee's Home Address **City** **State** **Zip Code**			**Home Phone #**
Employer's Name **Pyramid Diversified Services**	**Sex** ☐ M ☐ F	**Date of Employment** / /	
Marital Status ☐ Married ☐ Single ☐ Divorced/Legally Separated			
Do you have an eligible spouse? ☐ Yes ☐ No	**Number of eligible Children:**	**Indicate eligible dependents you wish to insure:** ☐ None ☐ Spouse ☐ Children ☐ Spouse & Children	

DEPENDENT INFORMATION – Complete If You Are Requesting Family Coverage

No person can be insured under this policy as both an Employee and a dependent, or as a dependent of more than one Employee. Please complete the following information for each family member you wish to cover.

Dependents Name (Last, First, Middle)	**Sex**	**Date of Birth**	**Relationship to Employee**	**Full-Time Student**
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No
				☐Yes ☐No

BENEFICIARY DESIGNATION

PRIMARY (P) – The person(s) you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage (%) has not been designated, then each will receive an equal share of the benefit.

CONTINGENT (C) - The person(s) you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage (%) has not been designated, then each will receive an equal share of the benefit.

NOTE: The Group Policyholder may not be named as a Beneficiary.

BENEFICIARY DESIGNATION

Full Name & Address	Date of Birth	Relationship	Primary (P) Contingent (C)	% of Benefit

This Is Important – Please Read

A new Enrollment Form must be completed for any changes such as name change, beneficiary change, birth of a child, adoption of a child. The new form must be **dated, signed,** and **attached** to your original Enrollment Form.

This Election for Coverage Cannot Be Processed Unless All Questions Are Answered And The Form Is Signed And Dated.

DECLINATION OF INSURANCE

I have been given the opportunity to elect the Group Insurance Benefits as provided under a plan of Group Insurance established by my Employer. I have decided **NOT** to elect this coverage. I understand that if I decide to elect this insurance at a later date, satisfactory proof of insurability will be required at my expense.

_____ _____

Employee Signature **Date Signed**

YES, I DO WANT THIS COVERAGE.

- I elect coverage for insurance for which I am or may become eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company.
- I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance. **(Not applicable if the Employer pays 100% of the required contribution)**.
- I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death.
- All information submitted by me on this form at Symetra Life Insurance Company's request, to the best of my knowledge and belief, is true and complete.

_____ _____

Employee Signature **Date Signed**

PART II – TO BE FILLED OUT BY THE EMPLOYER.

☐ **New Employee** ☐ **Late Entrant Enrollee** ☐ **Open Enrollment**

☐ **Change Requests – Effective Date of Change ____/____/____ Effective Date of Coverage ____/____/____**

Case Number **84750**☐ **84760**☐ **84770**☐ **Plan/Package Selected** _____

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