SYMETRA®
FINANCIAL

SELECT BENEFITS ENROLLMENT FORM

Mail completed forms to:
Select Benefit Administrators of America
118 3rd Street East or PO Box 440
Ashland, WI 54806
1-800-497-3699

This Election for Coverage Cannot Be Processed Unless all Questions Are Answered and the Form Is Signed and Dated.

PART I - TO BE COMPLETED BY THE CERTIFICATEHOLDER

Certificateholder's Name (Last, First, Middle)			Social Security #	Date of Birth / /
Certificateholder's Home Address	City	State	Zip Code	Home Phone #
Sex ☐M ☐F	Policyholder's Name		Date of Hire	

DEPENDENT INFORMATION - Complete if you Are Applying for Family Coverage

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

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

BENEFICIARY DESIGNATION - Complete if Your Policy has a Life Insurance Benefit

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

YES, I DO WANT THIS COVERAGE

- I elect coverage for insurance for which I am 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 Policyholder 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 is true and complete to the best of my knowledge and belief.

Please read the following notice that we are required by law to give to you.
It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Certificateholder Signature _____ Date Signed _____

A Change in Enrollment Status Form must be completed for any changes such as marriage/divorce, name change, beneficiary change, birth or adoption of a child. This new form must be dated and signed.

PART II - TO BE FILLED OUT BY THE POLICYHOLDER

☐ New Certificateholder ☐ Late Entrant Enrollee ☐ Open Enrollment Effective Date of Coverage ____/____/____

Case Number _____