| 1. EMPLOYEE'S LAS | T NAME FIRST NAM | ME MIDE | DLE INITIAL | 2. DA MON | TE OF BIRTH ITH DAY YEAR | GROUP NUMBER | | |
|---|--|---|--|--|---|--|--|--|
| 3. NAME OF EMPLOY | ÆR | 4. EMPLOYEE'S J | OB TITLE | 5. EN MON | MPLOYED FULL-TIME: TH DAY YEAR | 6. NUMBER OF HOURS WORKED PER WEEK | | |
| 7. SOME ONE LIVING HOUSEHOLD HAS DURING THE PAS | USED TOBACCO | NO□ | 8. MALE FEMALE | 9. SC | OCIAL SECURITY NO. | 10. GROSS MONTHLY SALARY | | |
| COMPLETE ONLY IF | 11. PRIMARY BENEFICIAR | Y'S LAST NAME | FIRST N | NAME | MIDDLE INITIAL | 12. RELATIONSHIP TO YOU | | |
| YOUR PLAN HAS EMPLOYEE LIFE INSURANCE | FULL ADDRESS OF BENEF | FICIARY | | | | PHONE | | |
| Contingent Benefi- | CONTINGENT BENEFICIAR | RY'S LAST NAME | FIRST NAME | M | DDLE INITIAL | RELATIONSHIP TO YOU | | |
| ciary to receive if no Primary Beneficiary is living. | FULL ADDRESS OF BENEF | FICIARY | | | | PHONE | | |
| COMPLETE ONLY IF YOU ARE PAYING ALL OR A PORTION OF THE PREMIUM Note: Evidence of Insurability may be required. COMPLETE ONLY IF | 13. I REQUEST THE FOLLO EMPLOYEE LIFE INSI DEPENDENT LIFE INS SHORT TERM DISABIL LONG TERM DISABIL ADDITIONAL (BUY) 14. MARITAL STATUS | Y JRANCE SURANCE ILITY INSURANCE ITY INSURANCE '-UP) LTD PLAN | ES NO | SHO ADI E | ORT TERM DISABILITY AMOUNT \$ DITIONAL/VOLUNTARY :MPLOYEE AMOUNT \$ | YES NO | | |
| YOUR PLAN HAS DEPENDENT LIFE | ☐ SINGLE ☐ MA☐ WIDOWED ☐ DIV | | TH DAY YE | AR | DEPENDENTS? (INCLUDE SPOU | | | |
| BENEFICIARY WHO DO MADE ACCORDING TO | ES NOT SURVIVE ME SHALL B THE TERMS OF THE POLIC BY MY EMPLOYER'S GROUP | E PAID TO THE CON CY, SUBJECT TO RE | TINGENT BENEFICE VOCATION BY ME (S), AND AUTHORI | IARY. IF N BY WRI | NO BENEFICIARY SURVITTEN NOTICE TO MY | JALLY AND THE SHARE OF A IIVES ME, PAYMENT SHALL BE EMPLOYER. I REQUEST THE N (IF ANY) FROM MY WAGES. | | |
| X DATE SIGNED. | | X EMPLOTEE 5 SIC | SNATURE | | UNITED HEDIT | AGE Life Insurance Company | | |
| Form 60-194 (Rev. 10/2 | 2003) GROUP INSURANC | E ENROLLMENT | CARD | | P.O. BOX 7777 | 7 - MERIDIAN,IDAHO 83680-77777 | | |
| 1. EMPLOYEE'S LAS | NAME FIRST NAM | ME MIDD | DLE INITIAL | MON | | GROUP NUMBER | | |
| 3. NAME OF EMPLOY | | 4. EMPLOYEE'S Jo | | MON | | 6. NUMBER OF HOURS WORKED PER WEEK | | |
| 7. SOME ONE LIVING HOUSEHOLD HAS DURING THE PAST | USED TOBACCO | NO□ | 8. MALE FEMALE | 9. SC — | CIAL SECURITY NO. | 10. GROSS MONTHLY SALARY | | |
| COMPLETE ONLY IF | 11. PRIMARY BENEFICIAR | Y'S LAST NAME | FIRST N | IAME | MIDDLE INITIAL | 12. RELATIONSHIP TO YOU | | |
| YOUR PLAN HAS EMPLOYEE LIFE INSURANCE | FULL ADDRESS OF BENEF | ICIARY | | | | PHONE | | |
| Contingent Benefi- | CONTINGENT BENEFICIAR | RY'S LAST NAME | FIRST NAME | MI | DDLE INITIAL | RELATIONSHIP TO YOU | | |
| ciary to receive if no Primary Beneficiary is living. | FULL ADDRESS OF BENEF | FICIARY | | | | PHONE | | |
| COMPLETE ONLY IF | 13. I REQUEST THE FOLLO | | S PROVIDED BY 1 | HE GRO | OUP POLICY ISSUED | TO MY EMPLOYER: YES NO | | |
| YOU ARE PAYING ALL OR A PORTION OF | | YES NO INSURANCE | | | | | | |
| | EMPLOYEE LIFE INSU | | DEPENDENT LIFE INSURANCE □ □ ADDITIONAL/VOLUNTARY (| | | | | |
| THE PREMIUM | | SURANCE | | | | | | |
| | DEPENDENT LIFE INS SHORT TERM DISABI LONG TERM DISABIL ADDITIONAL (BUY | SURANCE LITY INSURANCE ITY INSURANCE -UP) LTD PLAN | | 5 (| MPLOYEE AMOUNT \$ | \$ | | |
| THE PREMIUM Note: Evidence of Insurability may be | DEPENDENT LIFE INS SHORT TERM DISABI LONG TERM DISABIL | SURANCE LITY INSURANCE ITY INSURANCE -UP) LTD PLAN 15. BIRT RRIED MON | ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ | SE | MPLOYEE AMOUNT \$ POUSE AMOUNT | \$ | | |
| THE PREMIUM Note: Evidence of Insurability may be required. COMPLETE ONLY IF YOUR PLAN HAS DEPENDENT LIFE 17. UNLESS OTHERWI | DEPENDENT LIFE INS SHORT TERM DISABIL LONG TERM DISABIL ADDITIONAL (BUY 14. MARITAL STATUS SINGLE MA WIDOWED DIV SE PROVIDED HEREIN, BENE | SURANCE LITY INSURANCE ITY INSURANCE -UP) LTD PLAN 15. BIRT RRIED /ORCED MON 15. CON MON MON | HDATE OF SPOUS | SE AR | MPLOYEE AMOUNT \$ POUSE AMOUNT \$ CHILDREN'S BENEFIT 16. NUMBER OF ELI DEPENDENTS? (INCLUDE SPOU DS SHALL SHARE EQL | \$ | | |
| THE PREMIUM Note: Evidence of Insurability may be required. COMPLETE ONLY IF YOUR PLAN HAS DEPENDENT LIFE 17. UNLESS OTHERWI BENEFICIARY WHO DO MADE ACCORDING TO | DEPENDENT LIFE INS. SHORT TERM DISABIL LONG TERM DISABIL ADDITIONAL (BUY) 14. MARITAL STATUS SINGLE MADOWN MOOWED DIVENTING ME SE PROVIDED HEREIN, BENE ES NOT SURVIVE ME SHALL B | EURANCE LITY INSURANCE TITY INSURANCE LUP) LTD PLAN TRIED ORCED 15. BIRT MON ORCED FICIARIES DESIGNA E PAID TO THE CON Y, SUBJECT TO RE | HDATE OF SPOUS | SE AR PROCEEL ARY.IFN BY WRI | MPLOYEE AMOUNT SPOUSE AMOUNT SPOUSE AMOUNT 16. NUMBER OF ELI DEPENDENTS? (INCLUDE SPOU DISSIPPICIARY SURV THEN NOTICE TO MY | SE) JALLY AND THE SHARE OF A IVES ME, PAYMENT SHALL BE EMPLOYER. I REQUEST THE | | |

| | | | | FOR INSURANCE | COMPA | NY US | E ONLY | | | | |
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| EFF | EFFECTIVE DATE | | LIFE COVERAGES - CLASS OR AMOUNT | | | DISABILITY | | | | | |
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