1. EMPLOYEE'S LAST NAME | FIRST NAME | MIDDLE INITIAL

2. DATE OF BIRTH MONTH | DAY | YEAR

GROUP NUMBER

3. NAME OF EMPLOYER

4. EMPLOYEE'S JOB TITLE

5. EMPLOYED *FULL-TIME*: MONTH | DAY | YEAR

6. NUMBER OF HOURS WORKED PER WEEK

7. SOME ONE LIVING IN MY HOUSEHOLD *HAS* USED TOBACCO DURING THE PAST 12 MONTHS YES☐ NO☐

8. ☐ MALE ☐ FEMALE

9. SOCIAL SECURITY NO. — —

10. GROSS MONTHLY SALARY

COMPLETE ONLY IF YOUR PLAN HAS ***EMPLOYEE LIFE INSURANCE***

Contingent Beneficiary to receive if no Primary Beneficiary is living.

11. ***PRIMARY*** **BENEFICIARY'S** LAST NAME | FIRST NAME | MIDDLE INITIAL

12. RELATIONSHIP TO YOU

FULL ADDRESS OF BENEFICIARY

PHONE

CONTINGENT **BENEFICIARY'S** LAST NAME | FIRST NAME | MIDDLE INITIAL

RELATIONSHIP TO YOU

FULL ADDRESS OF BENEFICIARY

PHONE

COMPLETE ONLY IF YOU ARE PAYING ALL OR A PORTION OF THE PREMIUM

Note: Evidence of Insurability may be required.

13. I REQUEST THE FOLLOWING BENEFITS AS PROVIDED BY THE GROUP POLICY ISSUED TO MY EMPLOYER:

	YES	NO
EMPLOYEE LIFE INSURANCE	☐	☐
DEPENDENT LIFE INSURANCE	☐	☐
SHORT TERM DISABILITY INSURANCE	☐	☐
LONG TERM DISABILITY INSURANCE	☐	☐
ADDITIONAL (BUY-UP) LTD PLAN	☐	☐

	YES	NO
SHORT TERM DISABILITY INSURANCE	☐	☐
AMOUNT $ _____		
ADDITIONAL/VOLUNTARY GROUP LIFE INSURANCE		
EMPLOYEE AMOUNT $ _____	☐	☐
SPOUSE AMOUNT $_____	☐	☐
CHILDREN'S BENEFIT $_____	☐	☐

COMPLETE ONLY IF YOUR PLAN HAS ***DEPENDENT LIFE***

14. MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

15. BIRTHDATE OF SPOUSE MONTH | DAY | YEAR

16. NUMBER OF ELIGIBLE DEPENDENTS? (INCLUDE SPOUSE)

17. UNLESS OTHERWISE PROVIDED HEREIN, BENEFICIARIES DESIGNATED TO SHARE PROCEEDS SHALL SHARE EQUALLY AND THE SHARE OF A BENEFICIARY WHO DOES NOT SURVIVE ME SHALL BE PAID TO THE *CONTINGENT B*ENEFICIARY. IF NO BENEFICIARY SURVIVES ME, PAYMENT SHALL BE MADE ACCORDING TO THE TERMS OF THE POLICY, SUBJECT TO REVOCATION BY ME BY WRITTEN NOTICE TO MY EMPLOYER. I REQUEST THE INSURANCE PROVIDED BY MY EMPLOYER'S GROUP INSURANCE PLAN(S), AND AUTHORIZE THE REQUIRED DEDUCTION (IF ANY) FROM MY WAGES.

X DATE SIGNED_____ X EMPLOYEE'S SIGNATURE_____

UNITED HERITAGE Life Insurance Company

Form 60-194 (Rev. 10/2003) GROUP INSURANCE ENROLLMENT CARD

P.O. BOX 7777 - MERIDIAN,IDAHO 83680-7777

1. EMPLOYEE'S LAST NAME | FIRST NAME | MIDDLE INITIAL

2. DATE OF BIRTH MONTH | DAY | YEAR

GROUP NUMBER

3. NAME OF EMPLOYER

4. EMPLOYEE'S JOB TITLE

5. EMPLOYED *FULL-TIME*: MONTH | DAY | YEAR

6. NUMBER OF HOURS WORKED PER WEEK

7. SOME ONE LIVING IN MY HOUSEHOLD *HAS* USED TOBACCO DURING THE PAST 12 MONTHS YES☐ NO☐

8. ☐ MALE ☐ FEMALE

9. SOCIAL SECURITY NO. — —

10. GROSS MONTHLY SALARY

COMPLETE ONLY IF YOUR PLAN HAS ***EMPLOYEE LIFE INSURANCE***

Contingent Beneficiary to receive if no Primary Beneficiary is living.

11. ***PRIMARY*** **BENEFICIARY'S** LAST NAME | FIRST NAME | MIDDLE INITIAL

12. RELATIONSHIP TO YOU

FULL ADDRESS OF BENEFICIARY

PHONE

CONTINGENT **BENEFICIARY'S** LAST NAME | FIRST NAME | MIDDLE INITIAL

RELATIONSHIP TO YOU

FULL ADDRESS OF BENEFICIARY

PHONE

COMPLETE ONLY IF YOU ARE PAYING ALL OR A PORTION OF THE PREMIUM

Note: Evidence of Insurability may be required.

13. I REQUEST THE FOLLOWING BENEFITS AS PROVIDED BY THE GROUP POLICY ISSUED TO MY EMPLOYER:

	YES	NO
EMPLOYEE LIFE INSURANCE	☐	☐
DEPENDENT LIFE INSURANCE	☐	☐
SHORT TERM DISABILITY INSURANCE	☐	☐
LONG TERM DISABILITY INSURANCE	☐	☐
ADDITIONAL (BUY-UP) LTD PLAN	☐	☐

	YES	NO
SHORT TERM DISABILITY INSURANCE	☐	☐
AMOUNT $ _____		
ADDITIONAL/VOLUNTARY GROUP LIFE INSURANCE		
EMPLOYEE AMOUNT $ _____	☐	☐
SPOUSE AMOUNT $_____	☐	☐
CHILDREN'S BENEFIT $_____	☐	☐

COMPLETE ONLY IF YOUR PLAN HAS ***DEPENDENT LIFE***

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X DATE SIGNED_____ X EMPLOYEE'S SIGNATURE_____

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P.O. BOX 7777 - MERIDIAN,IDAHO 83680-7777

FOR INSURANCE COMPANY USE ONLY

EFFECTIVE DATE			LIFE COVERAGES - CLASS OR AMOUNT		DISABILITY				
MONTH	DAY	YEAR	LIFE	AD&D	DLI		STD BENEFIT	LTD - COVERED SALARY	E OF I
					Y N				Y N
					Y N				Y N
					Y N				Y N
					Y N				Y N
					Y N				Y N
					Y N				Y N
					Y N				Y N
					Y N				Y N
					Y N				

FOR INSURANCE COMPANY USE ONLY

EFFECTIVE DATE			LIFE COVERAGES - CLASS OR AMOUNT		DISABILITY				
MONTH	DAY	YEAR	LIFE	AD&D	DLI		STD BENEFIT	LTD - COVERED SALARY	E OF I
					Y N				Y N
					Y N				Y N
					Y N				Y N
					Y N				Y N
					Y N				Y N
					Y N				Y N
					Y N				Y N
					Y N				Y N
					Y N				