

Effective \_\_\_\_\_

Life \_\_\_\_\_

STD \_\_\_\_\_

**YORK COUNTY BUILDERS ASSOCIATION  
INSURANCE TRUST  
LIFE/DISABILITY ENROLLMENT FORM**

\_\_\_Initial

\_\_\_Change

\_\_\_Termination

\_\_\_Reinstatement

**TO BE COMPLETED BY THE EMPLOYEE**

<b>Name: Last, First, Middle Initial</b>		<b>Date of Birth: M/D/Y</b>	
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<b>Social Security Number</b>	<b>Sex</b> ___Male      ___Female	<b>Marital Status</b> ___Single      ___Widowed ___Married    ___Separated ___Divorced	
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<b>Street Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
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<b>Basic Life/Accidental Death &amp; Dismemberment</b> ___Yes      ___No	<b>Weekly Disability</b> ___Yes      ___No	<b>Long Term Disability</b> ___Yes      ___No
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**Beneficiary Designation** –Please refer to the reverse side of this form for important information regarding beneficiary designation.

<b>Primary Beneficiary (Full Name)</b>	<b>Date of Birth: M/D/Y</b>
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<b>Social Security Number</b>	<b>Sex</b> ___Male      ___Female	<b>Relationship</b>
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<b>Street Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
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<b>Contingent Beneficiary (Full Name)</b>	<b>Date of Birth: M/D/Y</b>
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<b>Social Security Number</b>	<b>Sex</b> ___Male      ___Female	<b>Relationship</b>
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<b>Street Address</b>	<b>City</b>	<b>State</b>	<b>Zip Code</b>
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\_\_\_\_\_ I hereby apply for coverage I have indicated above on behalf of myself and all dependents listed, and I authorize my Employer to make the appropriate deductions, if any, from my wages to pay for my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the contract between the insurer of The York County Builders Association Insurance Trust and my Group Plan.

\_\_\_\_\_ I hereby waive the coverages offered to me. I understand that if I desire to apply for any of these coverages at a later date, I will be required to furnish, at my own expense, medical evidence of support of insurability, that is satisfactory to the insurer, before my coverage will become effective.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**TO BE COMPLETED BY THE EMPLOYER**

<b>Employer Name</b>	<b>Occupation</b>
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<b>Date of Hire</b>	<b># of Hours Worked Per Week</b>	<b>Salary</b> \$ _____ ___Annual      ___Monthly ___Weekly      ___Hourly
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*For Policyholders covered under Pennsylvania Long Term Disability policies: If, within 90 days immediately prior to becoming covered under the group contract, you or any dependent have received medical care or advice for a disease or physical condition, you, he or she may not be covered for such disease or physical condition until you, he or she has been covered for one year under this contract. This exclusion, however, only applies to a disease or physical condition for which medical care or advice has been received within 90 days immediately prior to becoming covered under the group contract.*

## NAMING YOUR BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming you beneficiary or beneficiaries, please indicate their full name, address, social security number, relationship an, if a minor, the age of that minor. If the beneficiary is not related either by blood or marriage, insert the words, "Not Related". If you need assistance, contact you company representative or your own legal counsel.

*The following are examples of the most common designations:*

Mary J. Doe, Wife (*not* Mrs. John Doe)

Mary J. Doe, Wife, if living, otherwise to Joseph W. Doe, Son

Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter, and Joseph W. Doe, Son, in equal shares or to the survivor

Estate of the Insured

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "1/3 to Mary Jones, Mother, and 2/3 to Edith Jones, Wife".

If you find that more space is needed for naming your beneficiary or beneficiaries than that provided on this form, please complete a Beneficiary Designation Form GR-11927.