

INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.



Offered by Life Insurance
Company of North America

Employer: Boyd Company

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ Social Security # _____ Birthdate _____
 Address _____ City _____ State _____ Zip _____
 Work Phone _____ Home Phone _____ Employee ID # _____ Gender: _____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE

I am currently married and my date of marriage is: _____

My Spouse's Information Name _____ Social Security# _____
 Birthdate _____ Gender _____

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employee-Paid (Voluntary) Term Life Insurance Policy # FLX968834		
Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Units of \$10,000 up to the lesser of 5 times your salary, or \$500,000. Guaranteed Coverage: \$200,000	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$200,000* <input type="checkbox"/> \$500,000** <input type="checkbox"/> Other _____ <i>Amount must be a multiple of \$10,000.</i> <input type="checkbox"/> Decline Coverage
Spouse	Units of \$5,000 up to \$250,000. Guaranteed Coverage: \$50,000	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$50,000* <input type="checkbox"/> \$250,000** <input type="checkbox"/> Other _____ <i>Amount must be a multiple of \$5,000. The amount cannot exceed 50% of the employee's coverage.</i> <input type="checkbox"/> Decline Coverage
Child	Units of \$1,000 up to \$10,000.	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$10,000** <input type="checkbox"/> Other _____ <i>Amount must be a multiple of \$1,000.</i> <input type="checkbox"/> Decline Coverage

Employee-Paid (Voluntary) Accidental Death & Dismemberment Insurance Policy # OK 970307		
Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Units of \$10,000 up to the lesser of 5 times your salary, or \$500,000.	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$220,000 <input type="checkbox"/> \$500,000** <input type="checkbox"/> Other _____ <i>Amount must be a multiple of \$10,000.</i> <input type="checkbox"/> Decline Coverage
Spouse	Units of \$5,000 up to \$250,000.	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$110,000 <input type="checkbox"/> \$250,000** <input type="checkbox"/> Other _____ <i>Amount must be a multiple of \$5,000 and cannot exceed \$250,000.</i> <input type="checkbox"/> Decline Coverage
Child	Units of \$2,000 up to \$10,000.	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$10,000** <input type="checkbox"/> Other _____ <i>Amount must be a multiple of \$2,000.</i> <input type="checkbox"/> Decline Coverage

****This is the maximum amount that you can choose under this plan.**

All coverage elected during this enrollment period will take effect on the latest of 01/01/2019, the date your election form is received by your employer, or if applicable the day your Evidence of Insurability Form is approved by the Insurance Company.

SIGN HERE TO ACCEPT YOUR DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to New York Life Group Benefit Solutions' approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by KY: Life Insurance Company of North America.

Please Sign Here  Signature _____ Date _____

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