WMC INSURANCE

Life/Disability Enrollment Form

Enrollment E-mail Address: ins@wmc.org
Enrollment Customer Service #: 608-258-3400

Please print clearly in black ink being sure to sign and date this form. Return completed form to your HR Department.

Employee Information

Employee's Name (Last) (First) (M.I.)			Social Security Number	Date of Birth
Gender	Marital Status ☐ Single ☐ Married	Hours Worked Per Week	Date of Full-Time Employment	Annual Salary $

Type of Coverage

Coverage Election	Coverage Eff. Date	Coverage Election	Elected Supplemental Amount	Coverage Eff. Date
☐ Basic Life / AD&D		☐ Supplemental Employee Life		
☐ Basic Dependent Life		☐ Supplemental Spousal Life*		
☐ Short-Term Disability (STD)		☐ Supplemental Child(ren) Life*		
☐ Long-Term Disability (LTD)		* Employee must enroll in the supplemental life plan to enroll dependents		

Beneficiary Designation

If you have elected life insurance, please complete this section. If multiple beneficiaries are desired, please attach a separate list to this enrollment form. I hereby name the follow person(s) as beneficiary for any benefit payment upon my death.

Primary Beneficiary

Name _____

Address _____

Relationship _____

Contingent Beneficiary (if primary is deceased)

Name _____

Address _____

Relationship _____

Dependent Information (complete only if dependent coverage is available and elected)

(First) (M.I.) (Last)	Gender	Relationship	Date of Birth	Social Security Number
Spouse's Name				
Child				
Child				
Child				

Enrollment Election / Employee Authorization

☐ I hereby apply for the coverage 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 coverage available to me is in accordance with the provisions of the contract issued to WMC.

☐ I hereby **WAIVE** the coverage offered to me. I understand that if I and/or my dependents desire to apply for any waived coverage at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability that is satisfactory to the insurance company, before my dependents and/or my coverage will become effective.

Signature _____ Date Signed _____

Employer Section – please retain original in personnel file & e-mail a copy to WMC

Employer (Group) Name	Billing Number	Location/Division
Employee Class	Employee Occupation/Title	Work State

Status/Change: ☐ New Hire ☐ Retired ☐ Disabled ☐ Layoff / Leave of Absence ☐ Reinstatement

Status/Change Date: _____ ☐ Late Enrollee (Include Evidence of Insurability)