Genworth Financial

Genworth Financial
Employee Benefits Group

GE Group Life Assurance Company
Attn: Group Eligibility
100 Bright Meadow Blvd., PO Box 1955
Enfield, CT 06083-1955

ENROLLMENT REQUEST

☐ **Add** ☐ **Change** ☐ **Termination** ☐ **Correction**

Date: _____ **Reason:** _____

Employer Information - to be completed by Employer

1. Group Account Number	2. Other Group Account Number(s)	3. Class	Network	Billing Group

4. Name of Employer

5. Employer's Address (Number, Street, City, State, ZIP Code)

Employee Information - to be completed by Employee (This **entire** section must be complete to avoid processing delays)

6. Name of Employee (Last, First, M.I.)

7. Social Security Number

8. Employee's Address (Number, Street, City, State, ZIP Code)

9. Employee's Home Phone No.

10. Sex ☐ Male ☐ Female

11. Date of Birth (Mo., Day, Yr.)

12. Marital Status ☐ Single ☐ Married

13. My employment is covered under Union Collective Bargaining ☐ Yes

14. Hours worked weekly for this employer (Excluding Overtime)_____ ☐ Active ☐ Retired

15. Date Employed (Mo., Day, Yr.,) ☐ Full-Time ___/___/___ ☐ Part-time ___/___/___ ☐ Rehire ___/___/___ ☐ Return from Layoff ___/___/___

16. Basic Earnings $ _____ ☐ Hourly _____ Hrs/Wk ☐ Monthly ☐ Weekly ☐ Annually

17. Employee's Occupation (Title)

NOTE: If you refuse Medical or Dental benefits for yourself, you automatically refuse these benefits for any dependents. If you refuse any benefit now, and later request to add that benefit, your coverage may be limited as outlined in the certificate. Some or all of these benefits may be funded by your employer. Administrative Services and forms provided by GE Group Administrators, Inc. and/or GE Group Life Assurance Company does not imply liability for GEGA and/or GEGLAC for claim payment. See your employer for details. THOSE BENEFITS COMPLETELY PAID FOR BY THE EMPLOYER CANNOT BE REFUSED. All benefits may not be available; check with your plan administrator. Indicate your choice by checking the appropriate box(es).

Group Benefits Requested - to be completed by Employee

Life/AD&D	☐ I Elect	☐ I Refuse	Dependent Life/AD&D	☐ I Elect	☐ I Refuse	Supplemental Life/AD&D	☐ I Elect	☐ I Refuse
Dental	☐ I Elect	☐ I Refuse	Medical	☐ I Elect	☐ I Refuse	Weekly Indemnity	☐ I Elect	☐ I Refuse
Dependent Dental	☐ I Elect	☐ I Refuse	Dependent Medical	☐ I Elect	☐ I Refuse	Long Term Disability	☐ I Elect	☐ I Refuse

*If you have refused Medical or Dental, is it because you have other Group Coverage? Medical ☐ Yes ☐ No Dental ☐ Yes ☐ No

**If you have refused Medical or Dental for your dependents, is it because they have other Group Coverage? Medical ☐ Yes ☐ No Dental ☐ Yes ☐ No

Please Complete The Following Question If You Are Electing Medical Coverage

Did you or your dependent have prior medical coverage? ☐ Yes If so, ☐ Single ☐ Family ☐ Dependent(s)

☐ Individual Policy ☐ Group Policy ☐ HMO ☐ Other _____

Name of Carrier _____ Termination date of Coverage ____/____/____

Reason for Termination _____

Please complete this *entire* section if you are selecting Medical and/or Dental Coverage.

Relationship	Last Name	First Name	M.I.	Date of Birth	Sex	Social Security Number
Employee						/ /
						/ /
						/ /
						/ /
						/ /

Student Verification - Please complete the following if any child listed is a full-time college student.

Name of Child: _____ School Name and Address: _____

Course of Study: _____ Semester: _____ Anticipated Date of Graduation (month/year): _____

Beneficiary Designation - applies ONLY if life insurance is being elected at this time

22. Primary - Last Name	First Name & Middle Initial	Relationship	Address
23. Contingent - Last Name	First Name & Middle Initial	Relationship	Address

NOTE: You may designate a new beneficiary at any time, subject to the conditions and provisions of the Group Policy.

I request benefits under the group coverage issued by GE Group Life Assurance Company and the Group Benefit Plan(s) sponsored by my employer and authorize deductions from my earnings of any required contributions for any such coverage for which I am or may later become eligible. On behalf of myself and any dependents listed on this enrollment request, I apply, or as indicated, decline to apply for those benefit(s) for which I am eligible. I state that the information given as part of my enrollment request is true and correct and that this request is subject to the representations made on the reverse side of this request which I have read and fully understand. I understand and agree that any incorrect statements material to the risk made by me in this enrollment request may invalidate my benefit(s) and result in claim denials and that all statements made by me shall be deemed representations and not warranties.

I designate the beneficiary(ies) shown above to receive all sums which may become due on account of my death under this group coverage. I understand that proceeds will be payable in equal shares to those primary beneficiaries who survive me but if no primary beneficiary survives such proceeds will instead be payable in equal shares to those contingent beneficiaries who survive me.

To the best of my knowledge I am an employee working the weekly hours shown above at the employer's regular place of business, and I agree any information shown above including the **refusal section** is correct and my signing below indicates that I understand all information given is subject to verification.

I agree that my Employer acts as my agent in all dealings with the Plan(s), and that all notices given to him are binding upon me. I also agree that my participation in the benefit(s) and the authorization and agreements stipulated herein are subject to any future amendments to the Plan(s).

I certify that I have read the reverse side of this form.

24. Date	25. Signature