VOLUNTARY BENEFITS ELECTION FORM

ACRISURE

Please complete the form legibly and in its' entirety for processing.

EMPLOYEE INFORMATION			
Employee Name:		Social Security #:	
Date of Birth: / /	Gender: ☐ Male ☐ Female	Date of Hire: / /	
Home Address:	City:	State:	Zip:
I am a: ☐ Non-smoker ☐ Smoker	*Spouse (if applicable) is a: ☐ Non-smoker ☐ Smoker		

*DEPENDENT INFORMATION (ONLY IF APPLYING FOR DEPENDENT COVERAGES)			
Name (Last, First, M.I.)	Gender (M/F)	Date of Birth	Relationship to Employee

BENEFICIARY INFORMATION			
Name (Last, First, M.I.)	Address (if different than above)	Relationship	Phone #
Primary			
Contingent			

*EMPLOYEE WILL BE BENEFICIARY FOR ANY DEPENDENT COVERAGE

PLACE AN "X" IN YOUR DESIRED SELECTION(S) BELOW

Accident	Employee (EE) ☐	EE + Spouse ☐	EE + Children ☐	Family ☐	Waive ☐
Cancer	Employee (EE) ☐	EE + Spouse ☐	EE + Children ☐	Family ☐	Waive ☐

"I certify that I am actively at work on a full-time basis and able to perform all the duties of my occupation. (If applying for spousal and or dependent coverage) none of my dependents or spouse are currently disable. I certify that a life insurance illustration was not used in connection with this application, only a company-provided rate sheet may have been and no non-guaranteed values were illustrated. I authorize the carrier and Acrisure to electronically enter in the data I have provided here and will send a certificate for my review. I realize that any false statements may result in loss of coverage under the policy/certificate."

Signature _____ **Date** _____