Use this form to apply for the coverages listed below.
Late applicants are subject to Evidence of Insurability.
Basic Life/AD&D effective 03/01/08, Supplemental effective 04/01/08.

ENROLLMENT FORM

Group Life Insurance products provided by Unimerica Insurance Company.

A. EMPLOYEE INFORMATION

☐ Enroll ☐ Cancel ☐ Address Change ☐ Name Change ☐ Other Date

Last Name	First Name	M.I.	Social Security Number	Gender	Date of Birth

Street Address	Apt No.	City	State	Zip Code

Home Phone	Work Phone	Classification

Employer or Group Name	Division/Location	Subgroup Code	Job Title
Superior Court of California, County of Kern			

B. SPOUSE INFORMATION (complete only if applying for Supplemental Spouse Term life Insurance)

Last Name	First Name	M.I.	Social Security Number	Gender	Date of Birth

C. PRODUCT SELECTION - Application for (check all that apply):

Term Life Insurance

Basic Life Insurance	Coverage Amount: $10,000
Basic Accidental Death and Dismemberment	Coverage Amount: $10,000
Supplemental Employee Term Life Insurance	Coverage Amount: _____
Supplemental Spouse Term Life Insurance	Coverage Amount: _____ **(Complete Section B if Spouse Life > 0)**
Supplemental Child(ren) Term Life Insurance	**Coverage:** ☐ Yes ☐ No

D. BENEFICIARY DESIGNATION

Last name First Name M.I.	Address	Relationship	Gender	% of Death Benefit Payable to Beneficiary (must total 100%)
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	
			☐M ☐F	

E. SIGNATURE (This form must be signed)

I understand that by signing this form that I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected.

X _____ _____

Signature of Employee Date

F. EMPLOYER USE ONLY

☐ Initial Enrollment following policy start ☐ Initial enrollment following Date of Hire ☐ Late Applicant	Employee Effective Date (mm/dd/yyyy)	Signed for Employer by	Group Number **301718**

Unimerica℠ Workplace Benefits
A UnitedHealth Group Company