Specialty Benefits

Group Products
Underwritten by Dearborn Life Insurance Company

SMALL BUSINESS Association of MICHIGAN

Employee Enrollment & Change Form

When enrolling for the first time or making a change to an existing policy please use this form and send to the enrollment and billing team at the Small Business Association of Michigan per the contact information below.

Helpful tidbits to ensure that everything needed to process this form is completed:

- Check "New Enrollment" for new employee coverage or "Change" to change existing coverage.
- Fully complete the Employer/Employee Section remembering that each blank must be entered correctly (i.e. Date of Hire and Earnings are often missed but imperative to a successful form submission).
- Select the Basic Coverage offered by your employer **AND** the level of Voluntary Coverage you are requesting (if offered by your employer). The spouse's information must be entered if electing voluntary spousal Life AD&D.
- Fill out the Beneficiary Designation section if enrolling in Life/AD&D.
- Sign and date the form.
- If you are waiving coverage, please sign and date under the "Waiver of Coverage" section.

Send completed forms to SBAM:

Mailing Address: 101 S. Washington Square, Suite 900
Lansing, MI 48933

E-mail: MemberCare@sbam.org

Dearborn Life Insurance Company's group insurance products are offered as Specialty Benefits in cooperation with Blue Cross Blue Shield of Michigan. Specialty Benefits group insurance products are issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148.

Dearborn Life is a separate company and does not provide Blue Cross Blue Shield of Michigan products and is financially responsible for the products it issues.

Dearborn Life Insurance Company is an independent licensee of the Blue Cross and Blue Shield Association. Blue Cross Blue Shield of Michigan and Blue Care Network are nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association.

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SMALL BUSINESS Association of MICHIGAN

☐ New Enrollment ☐ Change

Employer/Employee Section

EMPLOYER			GROUP NO. / ACCOUNT NUMBER		LOCATION	
EMPLOYEE NAME - LAST	FIRST	MIDDLE INITIAL	GENDER ☐ M ☐ F	DATE OF BIRTH	DATE OF HIRE (FULL TIME)	
SOCIAL SECURITY NO.	EARNINGS $ Weekly ☐ Monthly ☐ Annual ☐			JOB TITLE		CLASS
HOME ADDRESS			CITY	STATE	ZIP	
HOME PHONE	WORK PHONE		CELL PHONE			

BENEFIT SELECTION - Life & Disability

COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. **Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.**

Basic Coverage

☐ Term Life / AD&D	☐ Short-Term Disability (STD)	☐ Long-Term Disability (LTD)
☐ Dependent Term Life		

Voluntary Coverage

Voluntary Coverage (check all that apply)		(A)Add, (C)Change (D)Delete	Total Amount of Coverage Desired	If (C)hange, list Prior Coverage
☐ Term Life / AD&D	Employee			
☐ Term Life / AD&D	Spouse			
☐ Term Life	Child(ren)			

SPOUSE NAME (if Applicant)	- LAST	FIRST	M.I.	SEX ☐ M ☐ F	SPOUSE DATE OF BIRTH	SPOUSE SOCIAL SECURITY #

To the best of the Applicant's knowledge and belief:

BENEFICIARY DESIGNATION: (For Employee Only: Must Be Completed if you have applied for Life or AD&D insurance.) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

	First Name	Last Name	Social Security No.	Date of Birth	Relationship	Percentage
Primary						%
Primary						%
Contingent						%
Contingent						%

FOR OFFICE USE ONLY

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy (ies) issued to the employer listed above. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I do not remain actively at work that my coverage may lapse or terminate. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.

EMPLOYEE SIGNATURE ____________________ DATE __________

Waiver of Coverage:

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the company.

EMPLOYEE SIGNATURE ____________________ DATE __________

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