

24-HOUR ACCIDENTAL DEATH & DISMEMBERMENT APPLICATION

Please complete each section in full

APPLICATION FOR BENEFITS

Employee name: _____ DMBA ID number: _____

Employer name: _____ Email: _____

Home address: _____ City: _____ State: _____ ZIP code: _____

Home phone: _____ Work phone: _____

I wish to enroll in 24-Hour Accidental Death & Dismemberment. I agree to pay the entire premium. I request to enroll in benefits as follows (check one plan and one benefit level):

BENEFIT PLAN

- Single plan (employee only)
- Family plan with children
- Family plan without children
- Family plan without spouse

BENEFIT LEVEL

- | | | |
|-----------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> \$20,000 | <input type="checkbox"/> \$100,000 | <input type="checkbox"/> \$200,000 |
| <input type="checkbox"/> \$30,000 | <input type="checkbox"/> \$120,000 | <input type="checkbox"/> \$300,000 |
| <input type="checkbox"/> \$40,000 | <input type="checkbox"/> \$140,000 | <input type="checkbox"/> \$400,000 |
| <input type="checkbox"/> \$60,000 | <input type="checkbox"/> \$160,000 | |
| <input type="checkbox"/> \$80,000 | <input type="checkbox"/> \$180,000 | |

ENROLLMENT INFORMATION

Complete the following information in full. List yourself and all legal dependents. **If you don't list all eligible dependents or add new dependents, they will not be enrolled.** Attach a separate sheet if necessary.

APPLICANT NAME (FIRST, MIDDLE INITIAL, LAST)	RELATIONSHIP TO EMPLOYEE	BIRTH DATE (MM/DD/YYYY)	SEX
	SELF		M F
	SPOUSE		M F
			M F
			M F
			M F
			M F
			M F
			M F
			M F

PARTICIPANT AUTHORIZATION

- I wish to enroll or make changes as indicated on this form.
- I wish to waive or discontinue participation in 24-Hour Accidental Death & Dismemberment.

If waiving or discontinuing benefits, I hereby acknowledge I have been given an opportunity to apply for 24-Hour Accidental Death & Dismemberment as offered by my employer and, after careful consideration, I have decided not to take advantage of this offer. **I understand I may enroll at a later time.**

If applying for benefits, I hereby acknowledge that I have read and agree to the terms and conditions of the benefits applied for herein. (For terms and conditions, see the summary plan descriptions at www.dmba.com.)

Also, it is mutually agreed that:

- The representations in this application are correctly recorded, complete, and true to the best knowledge and belief of the undersigned.
- Voluntary change to this benefit requires agreement between the employee and DMBA.
- No representative of any participating employer (except DMBA) is authorized to accept risks, pass upon eligibility, or waive any plan rights or requirements.
- The benefit applied for herein shall not go into force or take effect unless and until the application has been approved and the first premium has been collected during the good health of the person(s) to be enrolled.
- The benefit applied for herein, if approved, shall end upon failure to pay the premiums or as provided for in the plan.

Signature: _____ Date: _____

BENEFICIARY INFORMATION

To designate your beneficiaries, complete a *Beneficiary Form* or log in to www.dmba.com.

Please return this completed form to enrollmenthelp@dmba.com. You may also mail it DMBA, Attention: Member Services, P.O. Box 45530, Salt Lake City, UT 84145-0530 or fax it to 801-578-5933. For questions, visit www.dmba.com or call us at 801-578-5600 or 800-777-3622.