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

- ☐ $20,000
- ☐ $30,000
- ☐ $40,000
- ☐ $60,000
- ☐ $80,000
- ☐ $100,000
- ☐ $120,000
- ☐ $140,000
- ☐ $160,000
- ☐ $180,000
- ☐ $200,000
- ☐ $300,000
- ☐ $400,000

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

AUTHORIZATION

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 onto www.dmba.com.

WAIVER OF BENEFIT

Employee name: _____ DMBA ID number: _____

☐ I do not wish to enroll at this time.

☐ I wish to discontinue participation in 24-Hour Accidental Death & Dismemberment.

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.

Signature: _____ Date: _____

SIGN ONLY IF BENEFITS ARE REJECTED

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