Enrollment Form

Group Personal Accident Policy

ZURICH

Zurich American Insurance Company
1400 American Lane
Schaumburg, Illinois 60196

POLICYHOLDER INFORMATION	
Name of **Policyholder**: State of Wisconsin Group Insurance Board	Master Policy Number: GPA 0214266

ELIGIBLE PERSON INFORMATION				
Full Legal Name (First, Middle Initial and Last):			Last 4 Digits of SSN: XXX-XX-	
Street Address:		City:	State:	Zip Code:
Mailing Address (if different from above):		City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Domestic Partner		
Email Address:		Home Phone:	Work Phone:	Cell Phone:
Requested Effective Date (MM/DD/YYYY):		Certificate Number (assigned by the Company):		

SPOUSE/DOMESTIC PARTNER INFORMATION (if **Eligible Person** is applying for **Dependent** coverage)			
Full Legal Name (First, Middle Initial and Last):			Home Phone:
Street Address (if different than Eligible Person's):	City:	State:	Zip Code:
Date of Birth (MM/DD/YYYY):	Gender: ☐ Male ☐ Female		

DEPENDENT CHILD(REN) INFORMATION (if **Eligible Person** is applying for **Dependent Child(ren)** coverage)		
Full Legal Name (First, Middle Initial and Last):	Gender: ☐Male ☐ Female	Date of Birth (MM/DD/YYYY):
Full Legal Name (First, Middle Initial and Last):	Gender: ☐Male ☐ Female	Date of Birth (MM/DD/YYYY):

INSURANCE PROVIDED (please check each box that applies):

Contributory Coverage

Description	**Plan 1** **Accidental Death/Catastrophic Injury Coverage** **Principal Sum up to a maximum of $500,000**
Employee or **Member** Only:	☐ ☐ **Three (3) times** Active Employee's Base Annual Salary ☐ **Five (5) times** Active Employee's Base Annual Salary
Employee or **Member** & **Dependents**	☐ ☐ **Three (3) times** Active Employee's Base Annual Salary ☐ **Five (5) times** Active Employee's Base Annual Salary

The **Principal Sum** for covered **Dependents** will be a percentage of the **Insured's Principal Sum**.

BENEFICIARY DESIGNATION		
It is important that your beneficiary designation be clear so that there will be no question as to your intent. If you wish to name more than 1 primary or 1 contingent beneficiary, please attach a separate sheet of paper and include all the information requested. **NOTE: If designating more than 1 primary or 1 contingent beneficiary, the total % of share should not exceed 100% for each.**		
Primary Beneficiary (this beneficiary is the first in line to receive benefit(s))**:**		
Name (If an Individual, include First, Middle Initial and Last):	Date of Birth/Trust (MM/DD/YYYY):	% Share:
Relationship: ☐ **Spouse/Domestic Partner** ☐ Non-Spouse Individual ☐ Trust ☐ Estate ☐ Charity or Other Entity	SSN/Tax ID:	
Contingent Beneficiary (this beneficiary will only receive benefit(s) if the primary beneficiary has died)**:**		
Name (If an Individual, include First, Middle Initial and Last):	Date of Birth/Trust (MM/DD/YYYY):	% Share:
Relationship: ☐ **Spouse/Domestic Partner** ☐ Non-Spouse Individual ☐ Trust ☐ Estate ☐ Charity or Other Entity	SSN/Tax ID:	
If more than one primary and/or contingent beneficiary is designated and no percentage has been designated, settlement will be made in equal shares to such of the designated beneficiaries as survive the Insured, unless otherwise provided herein. If no designated beneficiary survives the Insured, settlement will be made to the Insured's estate, unless otherwise provided in the Accident Policy.		

PREMIUM INFORMATION:	
Per Pay Period Monthly: $	Frequency of Payment: ☒Monthly
Method of Payment: ☒ Payroll Deduction	

The **Eligible Person** hereby enrolls for Group Personal Accident Insurance and declares that:

All information provided in this enrollment form and any attachments hereto is true and correct. The undersigned understands that all information provided in this enrollment form and any attachments hereto is material to Zurich American Insurance Company's decision to provide this insurance, and that insurance will be provided by Zurich American Insurance Company in reliance upon the truth of such information. The undersigned understands that the insurance, if provided, may require contributions and if required, the undersigned authorizes payment via payroll deduction.

It is hereby understood and agreed that:

1. this insurance is provided by Zurich American Insurance Company in consideration of payment of the required premium; and
2. the insurance under the **Policy** begins no sooner than the date Zurich American Insurance Company or its Agent approves the Enrollment Form.

Eligible Person's Signature (may be electronic or print to sign): Date: