



# Aetna Life/Disability Enrollment Form

Enrollment E-mail Address: ins@wmc.org  
Enrollment Customer Service #: 800-236-5414  
Enrollment Fax #: 608-258-3413

Please print clearly in black ink being sure to sign and date this form. Return completed form to your Personnel Department.

Employee Information					
Employee's Name (Last)		(First)	(M.I.)	Social Security Number	Date of Birth
Gender	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Hours Worked Per Week	Date of Full-Time Employment	Annual Salary \$

Type of Coverage				
Coverage Election <input type="checkbox"/> Basic Life / AD&D	Coverage Eff. Date	Coverage Election <input type="checkbox"/> Supplemental Employee Life	Elected Supplemental Amount	Coverage Eff. Date
<input type="checkbox"/> Basic Dependent Life		<input type="checkbox"/> Supplemental Spousal Life*		
<input type="checkbox"/> Short-Term Disability (STD)		<input type="checkbox"/> Supplemental Child(ren) Life*		
<input type="checkbox"/> Long-Term Disability (LTD)		* Employee must enroll in the supplemental life plan to enroll dependents		

Beneficiary Designation	
If you have elected life insurance, please complete this section. If multiple beneficiaries are desired, please attach a separate list to this enrollment form. I hereby name the follow person(s) as beneficiary for any benefit payment upon my death.	
<u>Primary Beneficiary</u>	<u>Contingent Beneficiary</u> (if primary is deceased)
Name _____	Name _____
Address _____	Address _____
Relationship _____	Relationship _____

Dependent Information (complete only if dependent coverage is available and elected)						
(First)	(M.I.)	(Last)	Gender	Relationship	Date of Birth	Social Security Number
Spouse's Name						
Child						
Child						
Child						

Enrollment Election / Employee Authorization	
<input type="checkbox"/> I hereby apply for the coverage indicated above on behalf of myself and all dependents listed, and I authorize my Employer to make the appropriate deductions, if any, from my wages to pay for my share of the cost. I understand that the coverage available to me is in accordance with the provisions of the contract issued to WMC.	
<input type="checkbox"/> I hereby <b>WAIVE</b> the coverage offered to me. I understand that if I and/or my dependents desire to apply for any waived coverage at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability that is satisfactory to the insurance company, before my dependents and/or my coverage will become effective.	
Signature _____	Date Signed _____

Employer Section – please retain original in personnel file & e-mail or fax a copy to WMC			
Employer (Group) Name		Billing Number (69XXXX)	Location/Division
Employee Class		Employee Occupation/Title	Work State
Status/Change:	<input type="checkbox"/> New Hire <input type="checkbox"/> Retired <input type="checkbox"/> Disabled	<input type="checkbox"/> Layoff / Leave of Absence	<input type="checkbox"/> Reinstatement
Status/Change Date: _____	<input type="checkbox"/> Late Enrollee (Include Evidence of Insurability)		