Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200 | Bellevue, WA 98004-5135
Mailing Address: Benefits Division | PO Box 34690 | Seattle, WA 98124-1690
Phone 1-800-426-7784 | Fax 1-866-348-0056 | TTY/TDD 1-800-833-6388

GROUP LIFE INSURANCE – Member Enrollment

TO BE COMPLETED BY THE POLICYHOLDER

Policy Number **01-017168-00**

Policyholder Name **Big Valley Band of Pomo Indians of the Big Valley Rancheria**

Policyholder Address **2726 Mission Rancheria Road** (Street Address) **Lakeport** (City) **CA** (State) **95453** (Zip Code)

Contact information for the person designated to receive communications for the Policyholder regarding this insurance:

Name Veronica Rael - Aparicio Title Executive Assistant

Phone number 707-263-3924 Ext. 105 Email address vaparicio@big-valley.net

I. MEMBER INFORMATION

Name Sex ☐ M ☐ F

Street Address City State Zip Code

Home Telephone Number Date of Birth Marital Status

II. BENEFITS (Please check if you wish to enroll)	**Yes**	**No**	**Indicate the benefit amount.**
Member Basic Life	**X**		**$10,000**

Is the above member a minor? Yes____ No____ (If yes, complete Parent /Guardian info below)

1st Parent / Guardian:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

2nd Parent / Guardian:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Beneficiary Designation on Reverse

III. BENEFICIARY DESIGNATION

Policyholder Beneficiary: A percentage of your life insurance benefit will be paid to the Policyholder as shown in you certificate of coverage. Any remaining amount will be paid in accordance with your beneficiary designation below.

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

	NAME	ADDRESS	DATE OF BIRTH	RELATIONSHIP	% of BENEFIT
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					
☐ Primary ☐ Contingent					

IV. SELECTION/WAIVER OF GROUP INSURANCE *(Only check one box below, and sign.)*

☑ I, the undersigned, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. [I authorize the deduction from [funds distributed from the Policyholder of any contribution I am required to make toward the cost of this insurance. **(Not applicable if the Policyholder pays 100% of the required contribution).]**

☐ I, the undersigned, hereby waive my right at this time to elect the insurance coverage which I did not select above. I understand that if I do not enroll within 31 days, of the date I am first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death. All information submitted by me on this form to the best of my knowledge and belief is true and complete.

Member Signature _____ Date Signed _____

Group Benefits are insured by Symetra Life Insurance Company.