



**Group Term Life Insurance  
Enrollment Form**

**1. Information About the Employee**

**Enrollment Deadlines for New Employees:** New employees must enroll and sign this form within 30 days of their hire or eligibility date for group life insurance.

**New Enrollments**

- New Hire
- Late Enrollment

Title                      First Name                      MI                      Last Name                      Home Phone                      Email Address

Street                      City                      State                      Zip

Date Hired                      Birth Date                      Soc. Sec. No.                      Coverage Effective

Mo / Day / Yr                      Mo / Day / Yr                      - - -                      Mo / Day / Yr

*To be completed by  
Church Life for late enrollees*

- Active     Male     Married     Divorced     Clergy
- Retired     Female     Single     Other \_\_\_\_\_     Lay Employee

**2. Billing Information**

Name of Episcopal Organization                      Phone                      Email                      List Bill ID

Street                      City                      State                      Zip

**3. Amount of Employee Group Life Coverage**

Amount of Group Life Insurance: \$ \_\_\_\_\_                      Total compensation (total comp.) or annual salary: \$ \_\_\_\_\_

The amount of insurance is determined by the the group life contract your diocese or other institution has with Church Life Insurance Corporation. This contract may or may not cover dependents. Group Life insurance over \$500,000 is subject to approval and underwriting standards.

For clergy, their total comp. is the figure reported to The Church Pension Fund which includes cash stipend, housing, utilities, Social Security (SECA) offset. For lay employees, it is their annual salary plus bonus.

**4. Information about Dependents** (complete only if the Group Life contract covers dependents)

Dependents age 19-25 are eligible only if they are full-time students or physically or mentally handicapped. Include documentation with this form. If you need more space, attach an additional form.

Amount of Group Life Insurance	First/Last Name	Relationship	Soc. Sec. No.	Birth Date (Mo/Day/Yr)	Gender
\$ _____	_____	_____	____-____-____	____/____/____	<input type="checkbox"/> M
<input type="checkbox"/> Add	_____	_____	____-____-____	____/____/____	<input type="checkbox"/> F
\$ _____	_____	_____	____-____-____	____/____/____	<input type="checkbox"/> M
<input type="checkbox"/> Add	_____	_____	____-____-____	____/____/____	<input type="checkbox"/> F
\$ _____	_____	_____	____-____-____	____/____/____	<input type="checkbox"/> M
<input type="checkbox"/> Add	_____	_____	____-____-____	____/____/____	<input type="checkbox"/> F

**5. Important Information**

**Early Benefits:** The Group Life policy contains provisions that permit the payment of benefits in the event of terminal illness of the insured(s). Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. If the insured elects to receive accelerated death benefits, a lien is placed against a portion of the policy's death benefits associated with the acceleration of benefits.

**Beneficiaries:** Attach a completed *original* Beneficiary Designation Form to this enrollment form. You are the beneficiary of your dependent's benefit, if applicable. Contact Active Member Services for the form, or download it from [www.cpg.org](http://www.cpg.org). If you wish to change beneficiaries, complete a new designation form. This can be downloaded from [www.cpg.org](http://www.cpg.org).

**6. Signatures – Employee, Employer, and Sponsoring Diocese of Organization**

The employee, employer, and an officer of the sponsoring diocese or organization must sign this form.

IT IS REPRESENTED that all statements and answers to the above questions are complete and true to the best of my knowledge and belief and IT IS AGREED that all such statements and answers constitute the application, are binding on the Proposed Insured, and shall form the basis for and be part of any such proposed insurance provided by Church Life Insurance Corporation.

By signing, the employer certifies that the employee is eligible for the coverage applied for.

Employee's Signature	Date	Signature of an Officer at the Sponsoring Diocese/Org.	Date
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Employer's Signature	Date	Name of Sponsoring Diocese or Org.
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Address of Sponsoring Diocese/Org. (Street, City, State, Zip)