METROMONT CORPORATION

EMPLOYEE CONFIDENTIAL VOLUNTARY LIFE SELECTION

Effective Date:			CHECK HERE IF DECLINING COVERAGE: ☐

EMPLOYEE INFORMATION

FIRST NAME	MI	LAST NAME	M/F	DOB	SS#	Used Tobacco (last 12 mo)	
						○ Yes	◎ No
SPOUSE INFORMATION (If electing coverage)							
						◎ Yes	○ No
CHILD(REN) INFORMATION (If electing coverage)							

STREET ADDRESS:

CITY:	STATE	ZIP:	Annual Earnings: $
	DATE OF HIRE:	# Hours per week:	Class Type:
PHONE #: ( )		40	○ Hourly ◎ Salary

TERM LIFE	EMPLOYEE	(If Covered) SPOUSE	(If Covered) CHILD	TOTAL
20 Year Term	○ $100,000 ◎ $50,000	○ $25,000 ** ○ $15,000	◎ $10,000	
Payroll Deduction Amount(s):	$	$	$	$

New Hires - Guarantee Issue benefit amounts: $100,000 (Employee), $15,000 (Spouse), $10,000 (Child)
**(For higher benefit amounts: Complete application (CVT-AP-02-00) including Questions 1-6 for approval)

	Yes	No
Is this insurance being applied for intended to replace or change existing life insurance coverage?	○	○
If applying for spouse and/or child(ren) coverage is any proposed insured currently disabled? (If yes, provide name of proposed insured who will be excluded from coverage):	◎	◎

BENEFICIARY INFORMATION

First Beneficiary Name (List first and last name)	Percentage%	Relationship
	0%	
Second Beneficiary Name *(Only if you want to split %)*	Percentage%	Relationship
	0%	

By signing below, I agree to have premiums deducted from my pay for life insurance.

X_____ SIGNATURE	_____ DATE

* Mother's Maiden Name: _____ (Needed for electronic submission.)

Please sign this form and return it to your Human Resources representative.