



Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200
Bellevue, WA 98004

SELECT BENEFITS

**Westmont Chamber of Commerce & Tourism Bureau
Association Member Election Form Group #10387**

Mail to:
Select Benefit Administrators of America
118 3rd Street East
P.O. Box 440
Ashland, WI 54806
1-800-497-3699

Member Company Legal Name			Administrative Contact and Title
Street Address			E-mail Address
City	State	Zip	Telephone Number and Fax Number
Mailing Address			Requested Start Date
City	State	Zip	Nature of Business
Case Number 10387 Division _____	Eligible # of Employees	Eligible Classes of Employees	
Plan Selected Core Buy-Up Plans	Employer Contribution _____ hourly or _____ monthly		
Waiting Period for Plan Eligibility Coverage will be effective on the first of the month following (please choose one): <input type="checkbox"/> Date of Hire <input type="checkbox"/> 30 Days <input type="checkbox"/> 60 Days <input type="checkbox"/> 90 Days <input type="checkbox"/> Other _____			

Note: All Association Member Election Forms not fully completed will not be accepted and will be returned to the Agent/Broker.

Directions:

1. Complete this form in its entirety.
2. Attach the plan matrix chosen by the employer to the back of this sheet.

Conditions:

1. This Association Member Election Form is subject to acceptance by Symetra Life Insurance Company (Symetra).
2. This plan is not intended to replace major medical coverage.
3. All necessary administrative information concerning all covered persons shall be subject to the provisions of the policy and shall be furnished to Symetra by the participating employer.
4. All benefits shall be in accordance with those agreed to by Symetra.

Deposit:

A deposit of \$ _____ is hereby submitted to apply to the first premium payment due under the policy, if issued. Coverage is subject to Symetra Home Office approval and nothing contained herein shall be binding until approved. The deposit will be returned in full if coverage is not issued. Payment of a premium after delivery of the certificate shall constitute acceptance of the terms and conditions.

Employer's Election and Certification:

The undersigned employer hereby elects to participate in the Westmont Chamber of Commerce & Tourism Bureau's group policy and is affirmatively stating that they are members and eligible to participate in the group policy for its employees as now or hereafter in effect or modified.

I agree that all statements and answers recorded on this form are true and complete to the best of my knowledge and belief, and shall form a part of any policy issued.

Signed by _____ Title _____ Date _____

Servicing Agent's Certification:

I hereby certify that:

- a) All information set forth above is correct to the best of my knowledge;
- b) I have complied fully with the underwriting guidelines;
- c) I have explained this Association Member Election Form and the proposed insurance plan in detail to the employer; and
- d) To the best of my knowledge the above employer is financially sound.

I further certify that all agents involved in presentation of this account

- a) Are licensed by Symetra Life Insurance Company; or
- b) Have submitted the necessary paperwork to become a licensed agent through Symetra Life Insurance Company.

Name (Print) _TW_Group,_Inc._/ _Thomas_J._Walsh Jr.

Signature _____

Date _____

Address _520_N._Cass_Ave.,_Suite_201

Agent License Number _____

City _Westmont State _IL Zip _60559

Tax ID No. _362950422

Telephone No. _630-737-0300 Fax _630-737-0335

Commission Share _____ % Symetra Stat. Number _24-28-1023-10_





**SELECT BENEFITS
ENROLLMENT FORM**
Group 10387 Division _____

Mail completed forms to:
Select Benefit Administrators of America
118 3rd Street East or P.O. Box 440
Ashland, WI 54806
1-800-497-3699

This Election for Coverage Cannot Be Processed Unless all Questions Are Answered and the Form Is Signed and Dated.

PART I - TO BE COMPLETED BY THE EMPLOYEE

Employee's Name (Last, First, Middle)		Social Security #	Date of Birth ____/____/____
Employee's Home Address	City	State	Zip Code
Home Phone #			
Sex <input type="checkbox"/> M <input type="checkbox"/> F	Employer's Name	Date of Hire	
Plan Choice:	Core Plan _____	Buy-up #1 _____	Buy-up #2 _____
			Buy-up #3 _____

DEPENDENT INFORMATION - Complete if you Are Applying for Family Coverage

No person can be insured under this policy as both an Employee and a dependent, or as a dependent of more than one Employee. Please complete the following information for each family member you wish to cover.

Dependent Name (Last, First, Middle)	Sex	Date of Birth	Relationship to Employee	Full-Time Student
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

BENEFICIARY DESIGNATION - Complete if Your Policy has a Life Insurance Benefit

PRIMARY (P) - The person(s) you want to receive the life insurance benefit if you die. If more than one primary beneficiary is named, and a specific percentage is not designated, each receives an equal share of the benefit.

CONTINGENT (C) - The person(s) you want to receive the life insurance benefit if you die and no primary beneficiary is alive on that date.

If more than one contingent beneficiary is named, and a specific percentage is not designated, each receives an equal share of the benefits.

NOTE: The Group Policyholder may not be named as a Beneficiary.

BENEFICIARY DESIGNATION

Full Name & Address	Date of Birth	Relationship	Primary (P) Contingent (C)	% of Benefit

YES, I DO WANT THIS COVERAGE

- I elect coverage for insurance 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 my earnings of any contribution I am required to make toward the cost of this insurance.
(Not applicable if the Employer pays 100% of the required contribution.)
- 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 is true and complete to the best of my knowledge and belief.

Employee Signature

Date Signed

A Change in Enrollment Status Form must be completed for any changes such as marriage/divorce, name change, beneficiary change, birth or adoption of a child. This new form must be dated and signed.

PART II - TO BE FILLED OUT BY THE EMPLOYER

New Employee Late Entrant Enrollee Open Enrollment Effective Date of Coverage ____/____/____

Case Number **10387 Division** _____ **Member Co. is a Member of the Westmont Chamber of Commerce**