Life Insurance Company of North America

Personal Accident Insurance

POLICYHOLDER
Wyoming School Boards Association

POLICY No.
OK-960412

Complete the following to enroll:

Full Name__________________________________ Date of Birth ____/____/______
PRINT FULL NAME(S)

Address__________________________________ Social Security # ______-______-______
STREET

____
CITY STATE ZIP

Select Coverage Option:

☐ Employee/Member Only ☐ Employee/Member and Family Option 1 ☐ Employee/Member and Family Option 2

My Benefit Amount $____________ Total Cost $________/ per month

If you select coverage for your family, benefits for family members will be a percentage of yours.

My Beneficiary__________________________________ Relationship__________________________

You will be your family members' beneficiary unless you tell us otherwise in writing. Benefits will not be paid to your Domestic Partner if he or she is not specifically designated.

I enroll and authorize my employer to deduct the premiums from my earnings. I understand that the insurance selected will begin on the effective date as described in the brochure. If I am not actively at work, or my family members are not actively at work, or they are unable to engage in all the usual duties of a person of like age and sex, the effective date of coverage will be delayed until the individual returns to work, or the family member resumes usual duties.

SIGNATURE__________________________________ DATE_____/______/________

☐ **DECLINATION** — Check here and sign above if you do not want this coverage.

Return to your employer. Be sure to make a copy for your records.

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