Diocese of Winona-Rochester
Form B – 1 Insurance Enrollment For:

Basic Group (Term) Life (Policy #551767-18)
Long Term Disability (LTD) (Policy #551767-134)
& Accidental Death & Dismemberment (AD&D) (T5MP-BT-50621)

☐ Beneficiary change only. This form cancels all prior designations. Complete your name, SS# and beneficiary information along with signature and date.

☐This includes employee name change – prior name was_____

Employee Name (last, first, middle initial)	Policyholder Name	
	Diocese of Winona-Rochester	
Employee Address (street, city, state, zip code)	Social Security Number	Date of Birth

This form covers the following insurances:
Life ☒ Yes ☐ No Life Amount $ _____ LTD ☒ Yes ☐ No
AD&D ☒ Yes ☐ No AD&D Amount $ _____

Beneficiary* Information – Use additional sheet if needed

Name (last name, first, middle initial)	Relation to You:	Benefit %
If the Beneficiary(ies) named above are not living, then pay:		

*Note: Benefits cannot be sent directly to a minor. Please consult your policy for additional information

Request for Signature and Certification:

I understand that my Insurance coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief and understand that a copy of this form will be made available to me at my request. If applicable, I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature _____ Date _____ Work Phone _____ Home/Cell Phone _____