Application for
District Group Term Life Insurance

Group Policy No.: G-23,000-1	Account No.: 08	Policy Holder: Board of Pensions and Benefits USA, Church of the Nazarene	Effective Date of Coverage:

I. Applicant's Section:

Last Name: First Name: Middle Name: | Social Security No.: | Sex: _____ Male _____ Female | Date of Birth: ___________ mo. day year

Residence Address: ______________________________

City, State, ZIP: ______________________________

Home Phone No.: ______________________________

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Church Employer: ______________________ Job Title: ______________________

District Credential: ______________________

Spouse's Name:	Spouse's Date of Birth: ___________	Spouse's Social Security No.:

Number of dependent children 14 days to 19 years of age (or to 24 years of age if full-time student):

Beneficiary for Life Insurance Coverage (Print as: Doe, Mary A., **not** Mrs. John Doe):

Note: If more than one beneficiary is named, benefits will be divided equally among the surviving named beneficiaries. If other provisions are desired, contact Pensions and Benefits USA to secure the appropriate form to make such provision(s).

Last Name: First Name: Middle Name: Relationship to Applicant:

If a beneficiary is not related to you, indicate and give beneficiary's date of birth, Social Security number, or address:

Life Insurance Requested:

a. If applicable, Noncontributory Life (paid for by employer): ☐ Yes ☐ No

b. Contributory Life (paid for by applicant): ☐ Yes ☐ No

If yes: I hereby (1) request that coverage for which I am or may become eligible under the account number of the above group policy number issued by the Union Security Insurance Company; (2) authorize the required deductions, if any, from my earnings; (3) designate the beneficiary named on this application to receive the benefits payable in the event of my death; and (4) certify that any and all information disclosed on this application is correct.

If no: I understand that if I desire to apply for coverage at a later date, it may be necessary to furnish evidence of insurability at my own expense and that coverage will then become effective only upon approval of such medical coverage.

Date: **Signature of Applicant:**

II. To Be Completed by District Life Plan Sponsor:

______________________ (District Name)

Eligibility Date (Monday preceding first Sunday for which compensation is due): ___________ mo. day year

Date: Signature:

III. Pensions Office Section:

Date Approved:	Date Certificate Mailed:
Approved By:	Termination/Cancellation Date: