

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer Trustees of Delphi Salaried Retirees Association	Group Customer # 149752	Report # 238565	Sub Code 0001	Branch
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YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)		Social Security # - -	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)	

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that contributions are required for the benefits I select below.

- ▶ If you are enrolling during the initial enrollment period, you must complete the Health Information section of this form and the enclosed Authorization form:
 - If you are enrolling for more than \$50,000 of your Supplemental/Optional Life Insurance
 - If you are enrolling for more than \$10,000 of your Dependent Spouse Life Insurance
- ▶ If you are enrolling after the initial enrollment period, you must complete a Statement of Health form for all amounts you are requesting.

Term Life Insurance

Supplemental/Optional Life ¹

\$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000
 \$70,000 \$80,000 \$90,000 \$100,000 \$110,000 \$120,000

Dependent Spouse/Domestic Partner ² Life ^{1,3}

\$10,000 \$20,000 \$30,000 not to exceed 100% of your Supplemental/Optional Life Insurance amount.

Dependent Information

If you are applying for coverage for your Spouse, please provide the information requested below:

Name of your Spouse (First, Middle, Last) _____ Date of Birth (MM/DD/YYYY) _____

Male Female

¹ Life Insurance may include an Accelerated Benefits Option under which a terminally ill insured can accelerate a portion of his or her life insurance amount. An interest and expense charge may be deducted from the accelerated payment. Receipt of accelerated benefits may affect eligibility for public assistance. This benefit may be taxable and you are advised to seek assistance from a personal tax advisor.

² For Vermont and Washington State residents, Spouse includes your registered Domestic Partner if you and your Domestic Partner are registered as domestic partners, civil union partners or reciprocal beneficiaries with a government agency or office where such registration is available.

³ Amounts will be subject to state limits, if applicable.

Sign Here

Signature of Retiree

Print Name

Date Signed (MM/DD/YYYY)

GEF02-1 ADM
*(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana; **GEF02-1 ADM** applies to residents of Connecticut, North Dakota and Utah)*