

1. EMPLOYEE'S LAST NAME			FIRST NAME			MIDDLE INITIAL			2. DATE OF BIRTH MONTH DAY YEAR			GROUP NUMBER																
3. NAME OF EMPLOYER						4. EMPLOYEE'S JOB TITLE						5. EMPLOYED <i>FULL-TIME</i> : MONTH DAY YEAR			6. NUMBER OF HOURS WORKED PER WEEK													
7. SOME ONE LIVING IN MY HOUSEHOLD HAS USED TOBACCO DURING THE PAST 12 MONTHS YES <input type="checkbox"/> NO <input type="checkbox"/>								8. <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			9. SOCIAL SECURITY NO. - -			10. GROSS MONTHLY SALARY														
<i>COMPLETE ONLY IF YOUR PLAN HAS EMPLOYEE LIFE INSURANCE</i>	11. PRIMARY BENEFICIARY'S LAST NAME									FIRST NAME			MIDDLE INITIAL			12. RELATIONSHIP TO YOU												
	FULL ADDRESS OF BENEFICIARY												PHONE															
Contingent Beneficiary to receive if no Primary Beneficiary is living.	CONTINGENT BENEFICIARY'S LAST NAME									FIRST NAME			MIDDLE INITIAL			RELATIONSHIP TO YOU												
	FULL ADDRESS OF BENEFICIARY												PHONE															
<i>COMPLETE ONLY IF YOU ARE PAYING ALL OR A PORTION OF THE PREMIUM</i> Note: Evidence of Insurability may be required.	13. I REQUEST THE FOLLOWING BENEFITS AS PROVIDED BY THE GROUP POLICY ISSUED TO MY EMPLOYER:													YES		NO												
	EMPLOYEE LIFE INSURANCE						DEPENDENT LIFE INSURANCE						SHORT TERM DISABILITY INSURANCE						AMOUNT \$		YES		NO					
	<input type="checkbox"/>						<input type="checkbox"/>						<input type="checkbox"/>								<input type="checkbox"/>		<input type="checkbox"/>					
	SHORT TERM DISABILITY INSURANCE						LONG TERM DISABILITY INSURANCE						ADDITIONAL (BUY-UP) LTD PLAN						EMPLOYEE AMOUNT \$		SPOUSE AMOUNT \$		CHILDREN'S BENEFIT \$		YES		NO	
	<input type="checkbox"/>						<input type="checkbox"/>						<input type="checkbox"/>						<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
<i>COMPLETE ONLY IF YOUR PLAN HAS DEPENDENT LIFE</i>	14. MARITAL STATUS						15. BIRTHDATE OF SPOUSE						16. NUMBER OF ELIGIBLE DEPENDENTS? (INCLUDE SPOUSE)															
	<input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED						MONTH DAY YEAR																					
17. UNLESS OTHERWISE PROVIDED HEREIN, BENEFICIARIES DESIGNATED TO SHARE PROCEEDS SHALL SHARE EQUALLY AND THE SHARE OF A BENEFICIARY WHO DOES NOT SURVIVE ME SHALL BE PAID TO THE <i>CONTINGENT BENEFICIARY</i> . IF NO BENEFICIARY SURVIVES ME, PAYMENT SHALL BE MADE ACCORDING TO THE TERMS OF THE POLICY, SUBJECT TO REVOCATION BY ME BY WRITTEN NOTICE TO MY EMPLOYER. I REQUEST THE INSURANCE PROVIDED BY MY EMPLOYER'S GROUP INSURANCE PLAN(S), AND AUTHORIZE THE REQUIRED DEDUCTION (IF ANY) FROM MY WAGES.														X DATE SIGNED _____				X EMPLOYEE'S SIGNATURE _____										

Form 60-194 (Rev. 10/2003) GROUP INSURANCE ENROLLMENT CARD

UNITED HERITAGE Life Insurance Company
P.O. BOX 7777 - MERIDIAN, IDAHO 83680-7777

1. EMPLOYEE'S LAST NAME			FIRST NAME			MIDDLE INITIAL			2. DATE OF BIRTH MONTH DAY YEAR			GROUP NUMBER																
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	<input type="checkbox"/>						<input type="checkbox"/>						<input type="checkbox"/>								<input type="checkbox"/>		<input type="checkbox"/>					
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	<input type="checkbox"/>						<input type="checkbox"/>						<input type="checkbox"/>						<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>			
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