Ford Optional/Dependent Life Insurance Program
Bargaining Unit Employees - Hourly

Enrolment Form

☐ New Enrolment ☐ Election Change ☐ Beneficiary Change ☐ Self Pay for Commuted Value

Employee name: Last	First	Middle Initial	☐ Male ☐ Female	Seniority date	Age

Location code	Department	Global ID (GID)	Employee birth date	Present coverage election

Do you have an eligible spouse ☐ Yes ☐ No	Number of children	Date of Marriage (month, day, year)

Insurance Election

Note: By completing this Insurance Election section and signing this form, I hereby revoke all previous Optional Life Insurance elections I may have made.

Part 1 - Employee Life Insurance

Check one of the following options

Coverage Election

- ☐ Option 1 - $ 10,000
- ☐ Option 2 - $ 20,000
- ☐ Option 3 - $ 30,000
- ☐ Option 4 - $ 40,000
- ☐ Option 5 - $ 50,000
- ☐ Option 6 - $ 75,000
- ☐ Option 7 - $100,000
- ☐ Option 8 - $125,000
- ☐ Option 9 - $150,000
- ☐ Option 10 - $175,000
- ☐ Option 11 - $200,000
- ☐ Option 12 - $225,000
- ☐ I do not want employee insurance

Part 2 - Dependent Life Insurance

Check one of the following options

Coverage Election

	Spouse	Each Child
☐ Option 1 -	$ 5,000	$ 2,000
☐ Option 2 -	$10,000	$ 4,000
☐ Option 3 -	$15,000	$ 6,000
☐ Option 4 -	$20,000	$ 8,000
☐ Option 5 -	$25,000	$ 10,000
☐ Option 6 -	$30,000	$ 12,000
☐ Option 7 -	$35,000	$ 14,000
☐ Option 8 -	$40,000	$ 16,000
☐ Option 9 -	$45,000	$ 18,000
☐ Option 10 -	$50,000	$ 20,000
☐ Option 11 -	$55,000	$ 22,000
☐ Option 12 -	$60,000	$ 24,000

☐ I do not want dependent insurance

Note: I understand that if I desire to enrol after the eligibility date(s) as defined in the Certificate of Insurance, I or my spouse and eligible dependent children may be required to provide evidence of insurability satisfactory to the Insurance Company before elected coverage may become effective.

Beneficiary Designation

(Excluding Dependent Life Insurance which, in the event of the death of any of your dependent(s) is payable to you the Employee.) I hereby revoke any previous beneficiary designations in relation to my foregoing coverage(s) and designate the person(s) named below.

Note: If beneficiary is shown as irrevocable, his/her consent is required to change it. Include a signed and dated consent with this form. **You are responsible for ensuring the validity of your designation.**

For Quebec residents only

In Quebec, the designation of your spouse as beneficiary is irrevocable unless otherwise specified. If spouse is beneficiary, the designation is:

☐ Revocable ☐ Irrevocable

Beneficiary first name	Initial	Last name	Date of birth	Relationship	Percentage

I reserve the right to revoke this beneficiary designation. **Percentages must total 100% to be valid.**

Contingent Beneficiary

You may wish to designate a contingent beneficiary(ies) to receive any proceeds under this group policy if all of the primary beneficiary(ies), named above for either coverage, should die before you. In that event, a contingent beneficiary will automatically be entitled to the benefit that would have been payable to the primary beneficiary(ies). If you name more than one contingent beneficiary, then the proceeds will be split, evenly, amongst the contingent beneficiaries you choose to name. Should there not be any surviving beneficiaries at the time of your death, the proceeds will be paid to your estate.

Beneficiary first name	Initial	Last	Date of birth	Relationship	Percentage

Trustee Appointment

I appoint _____ as Trustee to receive any amount due to any beneficiary under the age of majority (not applicable in Quebec).

In accordance with the above election, I hereby authorize deductions from my earnings for the insurance herein applied for. This enrolment form supersedes any and all previous enrolment forms for coverage under the Group Insurance Policy No. 105456.

Date	Employee's signature

Return signed copy to Benefit Representative

Authorized Company Representative

Date	Signature

Effective date of change or date coverage is to commence:

_____