ReliaStar Life Insurance Company (Minneapolis, MN)
A member of the Voya® family of companies

CRITICAL ILLNESS ENROLLMENT FORM

Employee Name	SSN	Date of Birth

Home Address	City	State	Zip

Employer	Group Number/Account Number
Central New Mexico Community College (CNM)	**71211-6/001**

COVERAGE REQUESTED – Dependents are limited to ½ the amount elected by the employee/member

EMPLOYEE/MEMBER	☐ $10,000	☐ $20,000	☐ $30,000
SPOUSE/PARTNER	☐ $5,000	☐ $10,000	☐ $15,000
CHILD(REN)	☐ $5,000	☐ $10,000	☐ $15,000

COVERED DEPENDENTS– Complete only for those with elected amounts above

Dependent (Last Name, First Name)	Date of Birth	Gender	Social Security Number	Relationship
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ACKNOWLEDGEMENTS AND SIGNATURE:

Insurance benefits are contingent on proof of loss. Benefits may require medical information from your health care provider.

To the best of my knowledge and belief the information on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I authorize and instruct my Employer to deduct from my pay each pay period the premium due for my insurance coverage purchased through ReliaStar Life Insurance Company. This authorization and assignment will remain in effect until revoked by me in writing to my Employer. I understand that my coverage begins on the effective date assigned by ReliaStar Life Insurance Company, provided I am in active employment.

This application is part of the Policy and subject to the terms and conditions of the Policy. I understand that no agent, representative or employee of ReliaStar Life Insurance Company, my Employer or any other entity may change or waive the requirements of this application, or the terms of the Policy, the Certificate or any riders, except as specifically set forth in the Policy.

All statements herein are representations and not warranties.

Employee Signature_____ **Date**_____

For HR Use Only

Enrollment Type: ☐ Initial Eligibility ☐ Annual Enrollment ☐ Qualifying Event/Change Status Date _____

	EE Coverage	SP Coverage	DP Coverage	CH Coverage		DATE ENTERED
Code:					PDABENE	
DEDN Date:					PDADEDN	
BCOV Date:					PDABCOV	