

Life Insurance Enrollment and Change Form

Instructions: If you are enrolling for the first time or requesting a change to the amount of your optional life insurance, complete this form in its entirety. If you are requesting a change in beneficiary only, complete page two only. Return the completed form to your HR representative or the Insurance Department. Keep a copy for your records.

EMPLOYER INFORMATION (To be completed by a Benefits Administrator)	
Name of Employer: Crown Cork & Seal Company, Inc.	Group/Customer #: 117515 Sub: Branch:
Date of Hire (MM/DD/YYYY):	Coverage Effective Date (MM/DD/YYYY):

YOUR ENROLLMENT INFORMATION (To be completed by the Employee)			
Select one: ☐ New Hire Enrollment ☐ Change Request			Location/Plant #:
Social Security #:	First Name:		Last Name:
Address:		☐ Male ☐ Female	Email Address:
City:	St:	Zip:	Date of Birth: Phone #:

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that no contributions are required for Basic Life. I understand that contributions are required for the contributory life and spouse life benefits I select below.

- ▶ If you are enrolling during your initial enrollment period, you do not need to complete a Statement of Health form, **unless:**
 - You are enrolling for more than 3x your base wages or \$400,000 of Contributory Life Insurance
 - You are enrolling for more than \$25,000 of 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 ELECTIONS	
☒	Basic Life – Company-paid benefit equal to 1x base wages up to \$100,000
Employee Contributory Life Insurance Election – Employee paid coverage (a selection must be provided)	
☐	I waive Employee Contributory Life Insurance
☐	I elect Employee Contributory Life Insurance for the following amount (complete Option 1 or Option 2 below):
	Option 1 - Enter a multiple of \$10,000 up to a maximum of the lesser of 5x your base wages or \$500,000: \$ _____
	Option 2 - Select a multiple of base wages: ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x (up to \$500,000 of base wages)
To elect Spouse Contributory Life Insurance, you must elect Employee Contributory Life Insurance	
☐	I elect Spouse Contributory Life Insurance for the following amount:
	Enter a multiple of \$5,000 (\$10,000 minimum) up to \$250,000 (cannot exceed your contributory life insurance amount): \$ _____
SPOUSE INFORMATION	
If you are applying for coverage for your Spouse, please provide the following information:	
First Name:	Last Name: ☐ Male ☐ Female
Date of Birth (MM/DD/YYYY):	Social Security #:

FRAUD WARNING

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Life Insurance Beneficiary Designations

Instructions: You must provide a beneficiary designation for your Basic Life Insurance any time this form is submitted. If you elected Employee Contributory Life Insurance, you have the option to designate a different beneficiary for this portion of your coverage. If the Employee Contributory Life Insurance section below is not completed, your beneficiary for Employee Contributory Life Insurance will be the same as your designation for Basic Life Insurance.

Payment will be made in equal shares to multiple beneficiaries unless a share % is indicated; share % must total 100% Insurance due upon the death of a Spouse is payable to the Employee.

BASIC LIFE INSURANCE - This is a Company-paid benefit all employees are enrolled in automatically once eligible.

Name (First Last)	Social Security #	Birth Date	Relationship	Share %
Address	City	St	Zip	Phone #
Name (First Last)	Social Security #	Birth Date	Relationship	Share %
Address	City	St	Zip	Phone #
Name (First Last)	Social Security #	Birth Date	Relationship	Share %
Address	City	St	Zip	Phone #

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Name (First Last)	Social Security #	Birth Date	Relationship	Share %
Address	City	St	Zip	Phone #
Name (First Last)	Social Security #	Birth Date	Relationship	Share %
Address	City	St	Zip	Phone #

EMPLOYEE CONTRIBUTORY LIFE INSURANCE

Name (First Last)	Social Security #	Birth Date	Relationship	Share %
Address	City	St	Zip	Phone #
Name (First Last)	Social Security #	Birth Date	Relationship	Share %
Address	City	St	Zip	Phone #

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Name (First Last)	Social Security #	Birth Date	Relationship	Share %
Address	City	St	Zip	Phone #
Name (First Last)	Social Security #	Birth Date	Relationship	Share %
Address	City	St	Zip	Phone #

☐ Check here if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

DECLARATIONS AND SIGNATURE

By signing below, I understand that:

1. If I do not enroll for Contributory Life coverage during the initial enrollment period or if I request an amount of insurance that exceeds the guaranteed issue amounts specified above, I will be required to complete a Statement of Health form and coverage cannot be guaranteed.
2. Crown is authorized to deduct the required contributions from my earnings for my Contributory Life Insurance coverage.
3. I have the right to change my Contributory Life Insurance election or my designated beneficiary(ies) at any time.
4. By submitting this form, any previous designations of a beneficiary are hereby revoked.
5. I must be actively at work for coverage to take effect. If I am not actively at work on the effective date, coverage will begin on the date I return to active work.
6. If my spouse is hospitalized, confined at home under a physician's care, or receiving/applying for disability benefits from any other source on my spouse's effective date, such insurance will not take effect until my spouse is no longer hospitalized, confined or receiving disability benefits.
7. I have read and agree to the applicable Fraud Warning provided on this form.
8. The terms outlined in the contract between Crown and the insurance company take precedence over this application. Crown Cork & Seal Co., Inc. reserves the right to modify, suspend, change, or terminate the Crown Cork & Seal Company, Inc. Group Welfare Plan, in whole or in part, at any time.

Employee's Signature _____ Date _____

Employee's Name (Printed) _____ Plant Location _____