GROUP TERM LIFE/LTD ENROLLMENT FORM

PLEASE SEE PAGE 2 FOR IMPORTANT INFORMATION REGARDING THIS FORM

TO BE COMPLETED BY THE EMPLOYEE

Last Name: M.I. First Name LIFE ___YES____NO LTD ___YES____NO

SOCIAL SECURITY # | GENDER: ___M ___F | BIRTH DATE: M/D/Y

EMPLOYEE HOME ADDRESS STREET CITY STATE ZIP

BENEFICIARY DESIGNATION—Please refer to page 2 for important information regarding beneficiary designation. If extra space is necessary, please use the space on Page 2 titled "Beneficiary Designation Form."

PRIMARY:	D.O.B.	FULL NAME	ADDRESS	SSN	RELATIONSHIP
SECONDARY:	D.O.B.	FULL NAME	ADDRESS	SSN	RELATIONSHIP

____I hereby apply for the coverages I have indicated above on behalf of myself and I authorize my Employer to make the appropriate deductions, if any, from my wages to pay for my share of the cost. I understand that the coverages available to me are in accordance with the provisions of the contract between Lincoln Financial and my Group Plan.

Signature _____ Date _____

TO BE COMPLETED BY THE EMPLOYER

EMPLOYER NAME CLIENT CODE (IF APPLICABLE)

EMPLOYEE HIRE DATE REQUESTED EFFECTIVE DATE OF COVERAGE

COVERAGE: Indicate type of coverage below. You many only elect coverages reflected in your contract. To elect coverage check the box marked "Option 1" or "Option 2."

*BASIC LIFE ___OPTION 1 ___OPTION 2 | **LONG TERM DISABILITY ___OPTION 1 ___OPTION 2

***Earnings $ _____ ___Annual ___Monthly ___Weekly ___Hourly (Number hours/week _____)

Are you an active CPA?_____Yes_____No | To be completed by Banyan: Life Class ____ LTD Class ____

Please complete and return to: Banyan Administrators, 1215 Manor Drive, Suite 200, Mechanicsburg, PA 17055. Phone: (877) 480-7923 Fax: (877) 237-4519 CalCPAHealth@fnrm.com

PLEASE REVIEW THE FOLLOWING INFORMATION

For firms enrolling 2-3 employees - all applicants must fill out a personal health statement (available at calcpahealth.com)

Instructions:

- Have the employee thoroughly complete the top portion of the enrollment form (Page 1).
- For Life coverage, the employee must designate a beneficiary. Information on beneficiary designations is included below.
- Employer Name—If insurance plan covers multiple entities, always use the name of the entity to which the insurance contract was issued.
- Employee Hire Date—For new employees use the employee's date of hire. For current employees who move into an eligible class, be sure to use the date on which the employee became eligible—not the employee hire date.
- Requested Effective Date of Coverage—Date that the employee's coverage becomes effective under the group plan. For original and new employees this is the day after the new employee completes the designated Eligibility Waiting Period (established by the firm on their Subscription Agreement).
- Coverage—Check the "Y" or "N" boxes for coverages that are included in your policy and for which the employee is eligible.
- Earnings—The gross amount the employee earns. Be sure to indicate if the salary is Annual, Monthly, Weekly, or Hourly. Note: Changes in Earnings must be reported to Banyan Administrators.

NAMING YOUR BENEFICIARY—It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary *and* secondary beneficiary. When naming your beneficiary(ies) please indicate their full name, date of birth, address, social security number, relationship, and the percentage that should be allocated to that individual. If the beneficiary is not related either by blood or marriage insert the words "Not Related." If you need assistance, contact your company representative or your own legal counsel. If you name more than one beneficiary with unequal shares, please show the percentage of insurance to be paid to each beneficiary in the space below. If the following space does not meet your needs, please attach a letter that clearly states how you want the benefits to be paid.

*Basic Life Option 1 is defined as coverage of one times an employee's annual earnings up to $50,000. Option 2 is defined as coverage of two times and employee's annual earnings up to $100,000. Benefit levels will reduce by 35% at ages 65, 70, and 75 and by an additional 25% at ages 80, 85, 90, and 95.

**Long Term Disability Option 1 is defined as a monthly benefit of 60% of the Eligible Employee's monthly rate of basic earnings up to a maximum of $6,000 per month. Option 2 is defined as a monthly benefit of 60% of the Eligible Employee's monthly rate of basic earnings up to a maximum of $10,000 per month.

***Earnings Definition: Monthly Rate of Basic Earnings means the Eligible Employee's regular monthly rate of pay including bonuses and commissions average over the prior 12 months, excluding overtime, and any additional compensation; not to exceed the pay reported by the Employer.

BENEFICIARY DESIGNATION FORM - Please use this space if you need extra room to designate beneficiaries.					
PRIMARY:					
FULL NAME	D.O.B.	ADDRESS	SSN	RELATIONSHIP	%_____
FULL NAME	D.O.B.	ADDRESS	SSN	RELATIONSHIP	%_____
FULL NAME	D.O.B.	ADDRESS	SSN	RELATIONSHIP	%_____
FULL NAME	D.O.B.	ADDRESS	SSN	RELATIONSHIP	%_____
SECONDARY:					
FULL NAME	D.O.B.	ADDRESS	SSN	RELATIONSHIP	%_____
FULL NAME	D.O.B.	ADDRESS	SSN	RELATIONSHIP	%_____
FULL NAME	D.O.B.	ADDRESS	SSN	RELATIONSHIP	%_____
FULL NAME	D.O.B.	ADDRESS	SSN	RELATIONSHIP	%_____