

# ARAG® Legal Insurance Enrollment Form

# LOS RIOS

COMMUNITY COLLEGE DISTRICT

Please return to the Employee Benefits Department.

For assistance to complete this form, call 800-247-4184

## 1. ENROLLEE INFORMATION

**Name in Full**  
 First M.I. Last

**Mailing Address**  
 Number and Street  
 City State Zip Code

**Daytime Telephone Number**  
 - ext.

**Email Address**

**Employer/Association Affiliation**  
 Name of Employer/Association  
 Los Rios Community College District

**Employee ID**

**Date of Birth**  
 Month Day Year

**Gender**  
 M / F

**Date of Hire/Last Date of Employment/Date of Retirement**  
 Month Day Year

## 2. PLAN SELECTION AND FAMILY INFORMATION (Please Complete Applicable Information)

**UltimateAdvisor®**  
 Family: \$16.00 Per Month

**UltimateAdvisor Plus™**  
 Family: \$22.00 Per Month

Cancel my participation

Spouse/Domestic Partner First Name	Last Name	Gender - M/F	DOB: MM/DD/YY
Dependent First Name	Last Name	Gender - M/F	DOB: MM/DD/YY
Dependent First Name	Last Name	Gender - M/F	DOB: MM/DD/YY
Dependent First Name	Last Name	Gender - M/F	DOB: MM/DD/YY
Dependent First Name	Last Name	Gender - M/F	DOB: MM/DD/YY

## 3. AUTHORIZATION

By signing below, I am requesting enrollment or cancellation in the legal plan indicated above. I understand that the change in coverage will not become effective until the date assigned by the underwriter of the plan. I authorize my employer to deduct or cancel deductions for the cost of the plan as shown above, and as may be modified or adjusted, from my wages or salary.

Enrollee Signature Date MM/DD/YYYY

Limitations and exclusions apply. Insurance products are underwritten by ARAG Insurance Company of Des Moines, Iowa, GuideOne® Mutual Insurance Company of West Des Moines, Iowa or GuideOne Specialty Mutual Insurance Company of West Des Moines, Iowa. Service products are provided by ARAG Services, LLC. This material is for illustrative purposes only and is not a contract. For terms, benefits or exclusions, call 800-247-4184.

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