LIFE INSURANCE ENROLLMENT/CHANGE FORM

(***Please print or type***)

☐ **ENROLLMENT** ☐ **CHANGE** Effective Date of Coverage or Change _____/_____/_____

School Unit _____ Employee's Name (*Last, First, M.I.*) _____

Social Security # _____-_____-_____ Date of Birth ____/____/____ Sex (*Please Circle*) M F Occupation _____

Address _____
(*Street*) (*City*) (*State*) (*Zip*)

Home Telephone ( ) _____-_____ Work Telephone ( ) _____-_____ Hours Worked Weekly _____

❑ New Enrollee Date Hired _____/_____/_____
❑ Terminating Coverage Date _____/_____/_____
❑ Retired Date _____/_____/_____

❑ Single
❑ Married

❑ **DECLINE COVERAGE**

To enroll, you must be full time, regularly working 12½ hours salaried, or 16 hours hourly paid.

Annual Income (*Employer Must Complete*)

$ _____

Life & Accidental Death & Dismemberment– Choose only one

❑ Annual earnings ❑ 3 X annual earnings
❑ 2 X annual earnings ❑ 4 X annual earnings

Note: If you select 3 or 4 X annual earnings you are required to fill out a health questionnaire. This needs to be approved by underwriting before coverage will be effective.

Beneficiary Designation **(must equal 100%)**

Name (*Last, First, M.I.*) *(primary) /Social Security #* Relationship %

_____ _____ _____
_____ _____ _____
_____ _____ _____

If the above beneficiaries are not living, then pay:

_____ _____
(contingent)

Dependent Group Life Insurance

	☐ **Plan A**	☐ **Plan B**
Spouse	$5,000	$10,000
Children	$5,000	$ 5,000

Attained age at death
Age 14 days to 19 years
(or to and including age 25 if a full-time student)

Note: *Dependent life insurance may be purchased only if the amount of the insurance for the covered spouse or child does not exceed 50% of the employee's total insurance.*

*Subscribers may not elect dependent A or dependent B coverage for a spouse who is also a covered employee or who becomes a covered employee.

❑ I hereby authorize my employer to deduct from my earnings any payments, if applicable, for this coverage.

❑ I have declined all or a portion of the employee and/or dependent coverages. I understand that the Insurer has the right to require, at my expense, evidence of insurability for life insurance only in order to consider my request to change this decision, and that my request may be denied.

Fraud Statement *Any person who knowingly and with intent to defraud any insurance company or other person files a 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.*

Employee Signature _____ Employer Signature _____ Date Signed _____

Employers – For those DECLINING, keep this form for your records.