

**GROUP LIFE INSURANCE ENROLLMENT AND BENEFICIARY DESIGNATION FORM**  
(Please Print)

**All Eligible Employees Must Complete, Sign, and Date This Card**

Employee's Name (First) (Middle) (Last)

Social Security Number	Birthdate	Employment Date	Effective Date
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Beneficiary's Name (First) (Middle) (Last)	Relationship	Birthdate
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Beneficiary's Address	Percentage	SS#
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Beneficiary's Name (First) (Middle) (Last)	Relationship	Birthdate
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Beneficiary's Address	Percentage	SS#
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Beneficiary's Name (First) (Middle) (Last)	Relationship	Birthdate
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Beneficiary's Address	Percentage	SS#
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Other Arrangement Such As a Trust

**SUPPLEMENTAL AND DEPENDENT LIFE INSURANCE OPTIONS**

(Please Circle Yes or No)  
**SUPPLEMENTAL LIFE INSURANCE**

(Please circle Yes or No)  
**DEPENDENT LIFE INSURANCE**

Yes      No

Yes      No

**Guaranteed Issue up to \$50,000.00**

I understand that if I do not complete an evidence of insurability form and my supplemental life insurance is over \$50,000.00, I am declining coverage for over \$50,000.00. \_\_\_\_\_ Initial

**SUPPLEMENTAL AND DEPENDENT LIFE COVERAGE**

Name	Amount of Coverage	Birthdate	Required Medical Questionnaire	HUMAN RESOURCES USE ONLY	
				Effective Date	Denial Date
Employee					
Spouse					
Child					
Child					
Child					

Faculty \_\_\_ Staff \_\_\_

I understand that in addition to the University group term life insurance, I am eligible to purchase additional employee and dependent life insurance coverage. I hereby authorize the University to deduct the required contributions(s) from my earnings.

I also understand if I decline supplemental and or dependent coverage upon hire, but desire coverage at a later date, satisfactory evidence of insurability must be furnished to the life insurance company to determine eligibility.

Employee Signature: \_\_\_\_\_ Date Signed \_\_\_\_\_