



# Life Insurance Form

Form can be submitted via HR's secured fax at 937-775-3040

PERSONAL INFORMATION:		
UID:	First Name:	Last Name
SSN:	Birth Date:	Base Salary:
Address		
City	State:	Zip:

## BENEFICIARY DESIGNATION & ENROLLMENT STATUS INFORMATION:

BASIC LIFE EMPLOYER PAID	SUPPLEMENTAL EMPLOYEE TERM LIFE EMPLOYEE PAID	SUPPLEMENTAL DEPENDENT LIFE EMPLOYEE PAID
<p><b>Death Benefit</b> Staff &amp; Fiscal Faculty - 2x Base Salary Academic Faculty - 2.44x Base Salary</p> <p><b>Auto Enrolled</b> Your primary beneficiary is the person/persons who will receive the benefit payment from your policy if you were to die. The total percentage of the benefit can't exceed 100%.</p>	<p><b>Coverage Amount:</b> If you elect coverage over \$200,000, an Evidence of Insurability is required.</p> <p style="text-align: center;"> <b>1x Base Salary    2x Base Salary    3x Base Salary</b> </p>	<p><b>Spouse    \$10,000</b> <b>                 \$25,000</b></p> <p><b>Child(ren) - Up to age 26</b> <b>                 \$2,000</b> <b>                 \$10,000</b></p>
<b>Primary Beneficiary #1</b>	<b>Primary Beneficiary #1</b>	<b>Spouse</b>
Full Name:	Name:	Spouse's Name:
SSN:	SSN:	SSN:
Relationship:	Relationship:	Birthdate:
Percentage:	Percentage:	Disabled:    Yes    No
<b>Primary Beneficiary #2</b>	<b>Primary Beneficiary #2</b>	<b>Child #1</b>
Full Name:	Name:	Child's Name:
SSN:	SSN:	SSN:
Relationship:	Relationship:	Birthdate:
Percentage:	Percentage:	Disabled:    Yes    No
<b>Primary Beneficiary #3</b>	<b>Primary Beneficiary #3</b>	<b>Child #2</b>
Full Name:	Name:	Child's Name:
SSN:	SSN:	SSN:
Relationship:	Relationship:	Birthdate:
Percentage:	Percentage:	Disabled:    Yes    No

Please sign and date page 2.

<b>BASIC LIFE EMPLOYER PAID</b>	<b>SUPPLEMENTAL EMPLOYEE TERM LIFE EMPLOYER PAID</b>	<b>SUPPLEMENTAL DEPENDENT LIFE EMPLOYER PAID</b>
<b>Contingent Beneficiary #1</b>	<b>Contingent Beneficiary #1</b>	<b>Child #3</b>
Full Name:	Name:	Child's Name:
SSN:	SSN:	SSN:
Relationship:	Relationship:	Birthdate:
Percentage:	Percentage:	Disabled: Yes No
<b>Contingent Beneficiary #2</b>	<b>Contingent Beneficiary #2</b>	<b>Child #4</b>
Full Name:	Name:	Child's Name:
SSN:	SSN:	SSN:
Relationship:	Relationship:	Birthdate:
Percentage:	Percentage:	Disabled: Yes No
<b>Contingent Beneficiary #3</b>	<b>Contingent Beneficiary #3</b>	<b>Child #5</b>
Full Name:	Name:	Child's Name
SSN:	SSN:	SSN:
Relationship:	Relationship:	Birthdate:
Percentage:	Percentage:	Disabled: Yes No

*If designating more than 3 primary and/or 3 contingent beneficiaries, please attach additional sheets.*

**SIGNATURE:**

I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change upon entering a new age band.

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**Signature and Date**

**Delayed effective date of coverage:**

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Delayed Effective Date for New Enrollees: If your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please contact your plan administrator for an explanation of the delayed effective date provision that applies to your plan. Exception: Infants are insured from live birth.