Life Insurance Form

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

Check all that apply:
- ☐ Enrolling in coverage
- ☐ Increasing coverage amount
- ☐ Decreasing coverage amount
- ☐ Terminating coverage
- ☐ Beneficiary change

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**
Death Benefit Staff & Fiscal Faculty - 2x Base Salary Academic Faculty - 2.44x Base Salary **Auto Enrolled** Your primary beneficiary(s) will receive the benefit payment if you were to die. The total percentage of the benefit can't exceed 100%.	**For New Hires:** If you elect coverage over $200,000, an Evidence of Insurability is required. **1x Base Salary** ☐ **2x Base Salary** ☐ **3x Base Salary** ☐ **Decline Coverage** ☐	**Spouse** **$10,000** ☐ **$25,000** ☐ **Child(ren)** - *Up to age 26* **$2,000** ☐ **$10,000** ☐ **Decline Coverage** ☐
Primary Beneficiary #1	**Primary Beneficiary #1**	**Spouse**
Full Name:	Name:	Spouse's Name:
SSN:	SSN:	SSN:
Relationship:	Relationship:	Birthdate:
Percentage:	Percentage:	Disabled: Yes ☐ No ☐
Primary Beneficiary #2	**Primary Beneficiary #2**	**Child #1**
Full Name:	Name:	Child's Name:
SSN:	SSN:	SSN:
Relationship:	Relationship:	Birthdate:
Percentage:	Percentage:	Disabled: Yes ☐ No ☐
Primary Beneficiary #3	**Primary Beneficiary #3**	**Child #2**
Full Name:	Name:	Child's Name:
SSN:	SSN:	SSN:
Relationship:	Relationship:	Birthdate:
Percentage:	Percentage:	Disabled: Yes ☐ No ☐

Please sign and date page 2.

BASIC LIFE EMPLOYER PAID	SUPPLEMENTAL EMPLOYEE TERM LIFE EMPLOYEE PAID	SUPPLEMENTAL DEPENDENT LIFE EMPLOYEE PAID
Secondary Beneficiary #1	**Secondary Beneficiary #1**	**Child #3**
Full Name:	Name:	Child's Name:
SSN:	SSN:	SSN:
Relationship:	Relationship:	Birthdate:
Percentage:	Percentage:	Disabled: Yes ☐ No ☐
Secondary Beneficiary #2	**Secondary Beneficiary #2**	**Child #4**
Full Name:	Name:	Child's Name:
SSN:	SSN:	SSN:
Relationship:	Relationship:	Birthdate:
Percentage:	Percentage:	Disabled: Yes ☐ No ☐
Secondary Beneficiary #3	**Secondary Beneficiary #3**	**Child #5**
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.

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.