

**Dependent Life Insurance Enrollment & Change Form**  
**Staff Compensation System - Exempt/Coaches, Non-Exempt & Research (R1,R2)**

**Employee Information**

Effective Date / /	Employee Name	Employee ID	Department	Employee Group
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**Must be enrolled in Additional 1 Life Insurance to be eligible for dependent life insurance.**

**Spouse Life**

Enroll Upon Hire   
  Enroll Upon Marriage   
  Enroll through Evidence of Insurability   
  Reinstate-RFL  
 Waive Upon Hire   
  Terminate Coverage

Spouse Name	Amount of Coverage ( Increments of \$10,000; Max \$250,000) \$ *
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**\*Please note: if amount of coverage is greater than \$20,000, it is subject to medical underwriting approval\***

**Child Life** (eligible to age 26)

Enroll Upon Hire   
  Enroll Upon Birth/Adoption/Marriage   
  Reinstate-RFL  
 Waive Upon Hire   
  Terminate Coverage

Amount of Coverage (Increments of \$2,000; Max \$10,000) all children must be the same coverage amount  
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Last Name, First Name MI	Social Security Number - -	Date of Birth / /	Relationship
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Address	City	State	Zip Code
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Last Name, First Name MI	Social Security Number - -	Date of Birth / /	Relationship
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Address	City	State	Zip Code
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Last Name, First Name MI	Social Security Number - -	Date of Birth / /	Relationship
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Address	City	State	Zip Code
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Last Name, First Name MI	Social Security Number - -	Date of Birth / /	Relationship
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Address	City	State	Zip Code
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**NOTE:**

1. If you are enrolling in Spouse Life or Child Life you will automatically be the beneficiary of this coverage.
2. For qualifying events:
  - a. Please attach a copy of your marriage certificate if enrolling in Spouse Life.
  - b. Please attach a copy of each child's birth/adoption placement certificate if enrolling in Child Life for your own child(ren).
  - c. Please attach a copy of your marriage certificate to the child(ren)'s parent and a copy of each child's birth/adoption placement certificate if enrolling in Child Life for your step-child(ren) who is living in your home.

- I wish to apply for the insurance indicated above, or authorize the changes noted above.
- I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.
- I understand that if I waive Spouse Life insurance and at a later date wish to request such coverage, I will be required to furnish, which may be at my own expense, evidence of insurability satisfactory to the insurance carrier.
- I understand that if a qualified event occurs, I have 31 calendar days from the effective date of the event to apply for coverage.
- To the best of my knowledge and belief, the information I have provided is complete and correct.

<b>Employee Signature</b>	<b>Date</b> / /
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<b>HR USE ONLY</b>	HRA	Deduction Begin Date / /	HRPA
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