

Life Insurance Enrollment & Change Form

Employee Information

Effective Date / /	Date of Hire / /	Employee ID	Employee Group	Department
Last Name	First Name	MI	Date of Birth / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F

Enrollment Information – Employee Coverage

Type of Enrollment (check one):

Enroll Upon Hire
 Enroll through Evidence of Insurability
 Reinstatement-RFL
 Terminate Coverage
 Beneficiary Change

Basic Life Insurance (automatic enrollment) – Please provide beneficiaries

Beneficiary Designation Last Name, First Name MI	Change	Primary or Contingent	% Total Primary = 100% Contingent = 100%
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	

To view the life insurance plans available to you please visit: <http://www.standard.com/mybenefits/wmu/>

Additional 1 Life Insurance
 Waive Coverage

Beneficiary Designation Last Name, First Name MI	Change	Primary or Contingent	% Total Primary = 100% Contingent = 100%
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	

Additional 2 Life Insurance
 Waive Coverage
 Please select amount: 1 times or 2 times annual base salary

Beneficiary Designation Last Name, First Name MI	Change	Primary or Contingent	% Total Primary = 100% Contingent = 100%
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
	<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	

Please complete page 2 – Beneficiary Information, Employee Signature and Date

Beneficiary Information

Please complete for each beneficiary listed on Page 1

Last Name, First Name MI	Social Security Number - -	Date of Birth / /	Relationship
Address	City	State	Zip Code
Last Name, First Name MI	Social Security Number - -	Date of Birth / /	Relationship
Address	City	State	Zip Code
Last Name, First Name MI	Social Security Number - -	Date of Birth / /	Relationship
Address	City	State	Zip Code
Last Name, First Name MI	Social Security Number - -	Date of Birth / /	Relationship
Address	City	State	Zip Code
Last Name, First Name MI	Social Security Number - -	Date of Birth / /	Relationship
Address	City	State	Zip Code
Last Name, First Name MI	Social Security Number - -	Date of Birth / /	Relationship
Address	City	State	Zip Code
Last Name, First Name MI	Social Security Number - -	Date of Birth / /	Relationship
Address	City	State	Zip Code
Last Name, First Name MI	Social Security Number - -	Date of Birth / /	Relationship
Address	City	State	Zip Code
Last Name, First Name MI	Social Security Number - -	Date of Birth / /	Relationship
Address	City	State	Zip Code

- I wish to apply for the insurance indicated above, or authorize the changes noted on reverse side.
- 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 costs change.
- I understand that if I waive any of these insurance coverage's, and at a later date wish to request such coverage for myself, I will be required to furnish, which may be at my own expense, evidence of insurability satisfactory to the insurance carrier.
- To the best of my knowledge and belief, the information I have provided is complete and correct.

Employee Signature	Date / /
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HR USE ONLY 	HRA	Deduction Begin Date	HRPA
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