WESTERN MICHIGAN UNIVERSITY
Human Resources
1300 Seibert Administration Building, Mail Stop 5217
Phone (269) 387-3620 Fax (269) 387-3441

Life Insurance Enrollment and Change Form

Employee Information						
Effective Date	**Date of Hire**	**Department**		**Employee ID No.**		
Last Name	**First Name**		**MI**	**Date of Birth**		**Gender** ☐ M ☐ F
Email Address		**Daytime Phone Number**				

Enrollment Information – Employee Coverage

Type of Enrollment (check one):

☐ Enroll upon hire ☐ Enroll through evidence of insurability ☐ Beneficiary change
☐ Terminate coverage ☐ Reinstate – return from leave

Basic Life Insurance (automatic enrollment) – Please provide beneficiaries

Beneficiary Designation **Last Name**	**First name**	**MI**	**Change**	**Primary or Contingent**	**Total Primary = 100% Contingent = 100%**
			☐ Add ☐ Remove	☐ Primary ☐ Contingent	
			☐ Add ☐ Remove	☐ Primary ☐ Contingent	
			☐ Add ☐ Remove	☐ Primary ☐ Contingent	
			☐ Add ☐ Remove	☐ Primary ☐ Contingent	

☐ **Additional 1 life insurance** ☐ **Waive coverage**

Beneficiary Designation **Last Name**	**First name**	**MI**	**Change**	**Primary or Contingent**	**Total Primary = 100% Contingent = 100%**
			☐ Add ☐ Remove	☐ Primary ☐ Contingent	
			☐ Add ☐ Remove	☐ Primary ☐ Contingent	
			☐ Add ☐ Remove	☐ Primary ☐ Contingent	
			☐ Add ☐ Remove	☐ Primary ☐ Contingent	

☐ **Additional 2 life insurance** ☐ **Waive coverage**

Please select amount: ☐ 1x or ☐ 2x annual base salary

Beneficiary Designation **Last Name**	**First name**	**MI**	**Change**	**Primary or Contingent**	**Total Primary = 100% Contingent = 100%**
			☐ Add ☐ Remove	☐ Primary ☐ Contingent	
			☐ Add ☐ Remove	☐ Primary ☐ Contingent	
			☐ Add ☐ Remove	☐ Primary ☐ Contingent	
			☐ Add ☐ Remove	☐ Primary ☐ 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

- 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 coverages, 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

HR USE ONLY	HRA	Update ABBR Panel	Employee Group	Deduction Begin Date