



## Beneficiary Information for Employee Life Coverage

*(Beneficiary for Basic Employee Life and Employee Supplemental can be different.)*

*Life proceeds will be split equally among beneficiaries unless otherwise designated.*

**Note: The employee is the beneficiary for spouse or children insurance coverage, if applicable.**

Primary Beneficiary (Last Name, First, Middle Initial)	Address	Relationship	Benefit % (MUST total 100%)*
Contingent Beneficiary (Last Name, First, Middle Initial)	Address	Relationship	Benefit % (MUST total 100%)*

<p><b>Long-Term Disability (LTD)</b>                  Long-Term Disability coverage is employee-paid. Proof of Insurability is required if enrolling or increasing coverage level after 90 days from initial benefits eligibility.</p>	
<p><b>Long-Term Disability Election</b></p>	<p> <input type="checkbox"/> 50% (with \$50,000 AD&amp;D)  <input type="checkbox"/> 60%  <input type="checkbox"/> 70%    <input type="checkbox"/> Waive/Cancel                 </p>

**READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW**

- ❖ I authorize my employer to deduct from my pay the premium, if any, for the elected coverage.
- ❖ To the best of my knowledge and belief, the information I have provided on this form is correct.
- ❖ I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.
- ❖ I understand that coverage will begin the first of the month following my eligibility.
- ❖ I understand my coverage begins the first of the month following the completion and return of this form if a change is requested mid-year. If evidence of insurability is required, coverage will begin the first of the month following approval by the appropriate Insurance Underwriter.

<b>Employee's Signature</b>	<b>Date</b>
<b>Employee's Campus Phone</b>	<b>Home Phone</b> (   )

<b>OSU/A&amp;M Office Use Only</b>	Employee's Annualized Salary  \$ _____	EOI Required  Employee \$ _____  Spouse \$ _____	Eligibility for Coverage Confirmed  By:  Date:	Coded  By:  Date:
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