2016 OSU LIFE AND LONG-TERM DISABILITY ENROLLMENT/CHANGE FORM

EMPLOYEE INFORMATION – Please Print

Campus Wide ID: ___ ___ ___ ___ ___ ___ ___ ___ Social Security #: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Gender: M F

Employee Name: ________________________________ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Common Law

Home Telephone:___________________________________ Campus Telephone:__________________________________

Mailing Address:____

City:____________________________ State:_________Zip: _______________________ Email: ____________________________

Birth Date: __ __ / __ __ / __ __ __ __ Date of Hire __ __ / __ __ / __ __ Effective Date __ __ / 01 / 20__ __

Basic Employee Life/AD&D

Employee Only— Basic Life Insurance and Accidental Death and Dismemberment is OSU&/A&M System-provided (two times annualized salary not to exceed $200,000)

Supplemental Employee Life Insurance

☐ADD ☐DROP ☐WAIVE

☐ **I am currently enrolling in or have supplemental life coverage of: __ __ __, __ __ __ ($5,000 Increments)**

☐ **I am applying for additional supplemental life coverage of: __ __ __, __ __ __ ($5,000 Increments)**

The maximum guaranteed issued limit for Employee Supplemental Life Insurance is two times the annualized salary or $250,000, whichever is less. When you are first eligible for supplemental life coverage, you can elect this maximum limit without evidence of insurability. At each annual enrollment, you can elect to increase supplemental life coverage by $5,000 (total coverage not to exceed the maximum limit) without evidence of insurability. Total supplemental life coverage, up to five times the annualized salary not to exceed $750,000, is available if you complete an *Evidence of Insurability* form. ING/ReliaStar Life Insurance Company processes the form and additional coverage is effective when approved.

Maximum: $__ __ __, __ __ __ (for OSU Benefits Use only)

Supplemental Spouse Life Insurance

☐ADD ☐DROP ☐WAIVE

☐ **I am currently enrolling in or have supplemental life coverage of: __ __ __, __ __ __ ($5,000 Increments)**

☐ **I am applying for additional supplemental life coverage of: __ __ __, __ __ __ ($5,000 Increments)**

A spouse cannot be added for Supplemental Life Insurance if the spouse is also a benefit eligible employee of OSU. The maximum guaranteed issued limit for Spouse Supplemental Life Insurance is one times the annualized salary or $125,000, whichever is less. When initially eligible for spouse coverage, you can elect coverage in $5,000 increments without evidence of insurability up to one times your annual earnings not to exceed $125,000. At each annual enrollment, you can elect to increase spouse supplemental life coverage by $5,000 not to exceed the maximum limit. At all other times, an *Evidence of Insurability* form must be completed. ING/ReliaStar Life Insurance Company processes the form and coverage is effective when approved. Spouse coverage cannot exceed 50% of the employee's combined Basic and Supplemental amounts, up to a maximum of $375,000.

SPOUSE: Name: ____ SSN: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

Date of Birth: __ __/ __ __/ __ __ __ __ Gender: M F

Maximum: $__ __ __, __ __ __ (for OSU Benefits Use only)

Supplemental Dependent Child(ren) Life Insurance

☐ADD ☐DROP ☐WAIVE

When initially eligible for Dependent Child(ren) Supplemental Life Insurance, you can elect coverage without evidence of insurability. At all other times, you must complete an *Evidence of Insurability* form for your child(ren). ING/ReliaStar Life Insurance company processes the form and coverage is effective when approved. From birth to 14 days, the benefit amount is $100. From 14 days to 6 months, the benefit amount is $1,000. Dependent child coverage is limited to 50% of the employee's coverage amount. Children can be covered from birth to age 21. If a full-time student, dependent children may continue to be covered.

Elected Amount:

☐ $ 2,500 for each eligible dependent child
☐ $ 5,000 for each eligible dependent child
☐ $ 7,500 for each eligible dependent child
☐ $10,000 for each eligible dependent child

Beneficiary Information for Employee Life Coverage

Please list your beneficiary information below. Beneficiary for Basic Employee and Employee Supplemental Life can be different. Life proceeds will be split equally among beneficiaries listed, 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 (Street, City, State & Zip)	Relationship	Benefit % (MUST total 100%)*
Contingent Beneficiary (Last Name, First, Middle Initial)	**Address (Street, City, State & Zip)**	**Relationship**	**Benefit % (MUST total 100%)***

Long-Term Disability (LTD)

Long-Term Disability coverage is employee-paid.
Proof of Insurability is required if enrolling or increasing coverage level after 30 days from initial benefits eligibility.

LTD Election:

- ☐ 50% (with $50,000 Accidental Death)
- ☐ 60%
- ☐ Waive/Cancel

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. I understand that In the event in which I do not receive pay, premiums will be billed to my bursar account and are subject to cancellation for non-pay.
- 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.

EMPLOYEE SIGNATURE: ____ DATE: _____________________

Office Use Only	Employee's Annualized Salary $______________	EOI Required Employee $____________ Spouse $ ____________	Eligibility for Coverage Confirmed By: Date:	Coded By: Date: