2017 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 guaranteed issued(GI) life coverage of: __ __ __, __ __ __ ($10,000 Increments)**

☐ **I am applying for supplemental life by EOI of: __ __ __, __ __ __ ($10,000 Increments)**

The maximum GI limit for Employee Supplemental Life Insurance is two times the annualized salary or $300,000, whichever is less. When you are first eligible for supplemental life coverage, you can elect this maximum GI without evidence of insurability. At each annual enrollment, you can elect to increase supplemental life coverage by 4 increments of $10,000 (total coverage not to exceed the maximum GI limit) without EOI. 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 online. Liberty Mutual processes the form and additional coverage is effective after approved.

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

Supplemental Spouse Life Insurance

☐**ADD** ☐**DROP** ☐**WAIVE**

☐ **I am currently enrolling in or have supplemental life GI coverage of: __ __ __, __ __ __ ($10,000 Increments)**

☐ **I am applying for additional supplemental life by EOI of: __ __ __, __ __ __ ($10,000 Increments)**

A spouse cannot be added for Supplemental Life Insurance if the spouse is also a benefit eligible employee of OSU. The maximum GI limit for Spouse Supplemental Life Insurance is one times the annualized salary or $130,000, whichever is less. When initially eligible for spouse coverage, you can elect coverage in $10,000 increments without an EOI up to one times your annual earnings not to exceed $130,000. At each annual enrollment, you can elect to increase spouse supplemental life coverage by $10,000 not to exceed the maximum GI limit. At all other times, an *Evidence of Insurability* form must be completed online. Liberty Mutual processes the form and coverage is effective after approved. Spouse coverage cannot exceed the maximum limit of $380,000.

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. From birth to 14 days, the benefit amount is $100. From 14 days to 6 months, the benefit amount is $1,000. Children can be covered from birth to age 26. 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%)***

2017 Long-Term Disability (LTD)

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

LTD Election:

- ☐ 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: