

To Be Completed By Human Resources

Group Number 163095	Division Class 2	Billing Category N/A	Date of Employment
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To Be Completed By Applicant ☒ Apply for Coverage ☐ Beneficiary Change *Complete Beneficiary Section below.* ☐ Name Change
☐ Add or ☐ Delete Dependent Date of add/delete _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	☐ Male ☐ Female
Your Address	City	State	ZIP
Former Name (Last, First, Middle) <i>Complete only if name change</i>		Phone Number	

Employer Name Kentucky Wesleyan College	Job Title/Occupation
Hours Worked Per Week full-time	Earnings \$ _____ Per: ☐ Hour ☐ Week ☐ Month ☐ Year

Coverage Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.

1. Life and Accidental Death and Dismemberment (AD&D) Insurance

- | | | |
|---|---|--|
| ☐ Life (Employer Paid) | ☐ Voluntary Life | Your requested amount \$ _____ |
| ☐ Life with AD&D (Employer Paid) | ☐ Voluntary Life with AD&D | Your requested amount \$ <u>2 times base pay</u> |
| ☐ Additional/Optional Life | ☐ Additional/Optional Life with AD&D | Your requested amount \$ _____ |

2. Dependents Life and AD&D Insurance

- | | |
|---|--|
| ☐ Spouse Life Requested amount \$5,000 _____ | ☐ Spouse Life with AD&D Requested amount \$ _____ |
| Spouse Name _____ Date of Birth _____ | |
| ☐ Child(ren) Life Requested amount \$2,500 _____ | ☐ Child(ren) Life with AD&D Requested amount \$ _____ |

3. Voluntary Accidental Death and Dismemberment (AD&D) Insurance

- | | | |
|--|--|--|
| ☐ You only \$ _____ | ☐ Your Spouse \$ _____ or _____ % | ☐ Your Child(ren) \$ _____ or _____ % |
|--|--|--|

4. Supplemental Life Insurance

- | | |
|---|---|
| ☐ Your requested amount \$ _____ | ☐ Spouse requested amount \$ _____ |
|---|---|

5. Short Term Disability

- | | | |
|--|--|---------------------------------|
| ☐ Employer Paid | ☐ Voluntary STD | ☐ Buy-up |
|--|--|---------------------------------|

6. Long Term Disability

- | | | |
|--|--|---------------------------------|
| ☐ Employer Paid | ☐ Voluntary LTD | ☐ Buy-up |
|--|--|---------------------------------|

7. Dental (see below)

- | | | |
|--|---|--|
| ☐ Employer Paid | ☐ Voluntary Dental | ☐ Low Dental Plan ☐ High Dental Plan |
|--|---|--|

8. Vision (see below)

- | | | |
|--|--------------------------------|---|
| ☐ Employer Paid | Voluntary Balanced Care Vision | ☐ Plan 1 ☐ Plan 2 ☐ Plan 3 |
|--|--------------------------------|---|

Beneficiary This designation applies to coverage available through your Employer, if any, under Coverage Section 1 or 3 above. Unless specified otherwise on a separate sheet of paper, this designation will also apply to coverage available through your Employer, if any, under Coverage Section 4 above. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See below for further information.

Primary – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. if known	Relationship	% of Benefit Total must equal 100%

Contingent – Full Name	Address	Birth Date	Phone No.	Soc. Sec. No. if known	Relationship	% of Benefit Total must equal 100%

Signature

I wish to make the choices indicated on this form. If electing coverage, 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 or costs change.

Member/Employee **Signature Required** _____ **Date** (Mo/Day/Yr) _____

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
 1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
 2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
 3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

Return completed form to your Human Resources Department.