

## Life & AD&D Insurance And Supplemental Coverage Application

Life Insurance Group Enrollment Fo		Com	parry	oi C	an	aua	ı T	=ffective	Date _ Enroll	ment		Change	<del></del> -
All Regular, fu	II-time	employe	es must o	complete	all	sections	of th	— is form ar	nd then	send	it·	_	
via Campus Mail, or US Mail to Benefits  General Information	Starr, F	IR Office,	412 Spar	rks Hall, N	/lurra	ay, KY, 42	2071	or via f	ax to B	enefits	Staff, HR	Office 2	70-809-346
Employer Name & Address Policy num									IL	ocation			
Murray State University, 412 Sparks Hall, Murray, KY 42071							065		Murray, KY				
Employee Information								river see				.,,	
Employee's Full Legal Name			Male	Date	of Birt	h		Marital stat	tus I	Hire Dat	e (Reg FT)	# of ho	ours / week
			Female	•			ļ					□ 3	7.5 hrs.
Street Address		City			_		State	- 2	Zip code		4	0 hrs.	
Social Security No.	Eamin	igs			Jo	b Title				_			
M#	_			Annually	F.	Mail				_			
,	\$		L 1	Hourly	-	141211							
Employee Basic Life and AD&D (Employer-paid		Supplemental Life and Add Supplemental AD&D					☐ Del ☐ Change			ge Rates: \$.24 per month per \$1,000. Must be in			
\$10,000)		Coverage Amount \$							increments of \$10,000.				
Beneficiary Designation If two or more print to the named primary beneficiaries. If no print benefit percentages must equal 100%. Attack	mary be	eneficiary	survives	the emplo	vee	. proceed	ls will	be paid to	the co	ntinge	nt beneficia	rv(ies)	The total
PRIMARY Beneficiary(ies) — List Full Legal Name FIRST NAME MI LAST NAME			ADDRE	=99			DEI /	TIONSHIP	BIRTH	DATE	SOCIAL SEC	UDITY#	DENETITO *
							KEL	TIONSHIP	ыкти	DATE	XXX-XX-	UKII Y #	BENEFITS %
									-		XXX-XX-	_	%
			_		_				-		XXX-XX-		- %
			·-										100
CONTINGENT Beneficiary(ies) — List Full Legal Name								I	<u> </u>				
				_							XXX-XX-		%
											XXX-XX-		%
											XXX-XX-		%
													1009
Evidence of Insurability A medical Evidence of Insurability ("EOI") application	n is nee	ded if:	The state of										
<ul> <li>This application is for coverage greater than \$ teed issue amount). Coverage can not excee</li> <li>Coverage is declined now and then is request</li> <li>Coverage subject to Evide</li> </ul>	\$250,000 ed \$500,0 ted later.	) (the Maxir 000.			þ	pen enrolli any of Car	ment, nada c	whether exi- or a prior ins	sting cov	verage i carrier.	overage abo is with Sun L	ve \$250, ife Assur	000 during ance Com-
Fraud Warning in Kentucky						THE PERSON NAMED IN				330			
Any person who knowingly and with intent to defrau false information or conceals, for the purpose of mis subjects that person to criminal and civil penalties.	id any in sleading,	surance co , information	mpany or on concernic	other persong ng any fact	n file mat	es an applic erial theret	cation to com	for insurand mits a fraud	e or stat	tement surance	of claim cont act, which n	taining ar	ny materially crime and
Employee Acknowledgement	27:55					18 - 1 -							
I understand that:         I am requesting insurance coverage under a 0 my employer.         My employer will deduct the premium for contifrom my pay.			-	•	s	urance Co. ection.	mpany		, and I h	ave rea	st be accepta id the "Evide		
<ul> <li>Coverage &amp; any payroll deductions will end with chose to continue coverage by contacting the</li> <li>I may be subject to medical questions or examiside of my eligibility period or requesting an in guaranteed issue amount.</li> </ul>	carrier on if I am	lirectly. electing co	verage out	_	• If	I am not a ne date tha	ctively at any i	at work du nitial or incr	e to injur eased c	ry, illnes overage	ss, layoff or le e is schedule te I return to	d to start	bsence on under the
By signing below, I am verif	ying that	t the inform	ation I hav	e provided	is tru	e and com	rect to	the best of	my knov	vledge a	and belief.		
Employee Signature									Date	e		/	