Employee Life Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. All new coverage or any increases in coverage will require proof of good health if plan participation requirements are not met. Any references to coverage being obtained without proof of good health in the sections below are only applicable if the plan participation requirements are met.

Name of Employer/Plan Sponsor Southern Illinois University			Group/Plan Number 65708-5	Account Number/Location 1 – Carbondale/Springfield
State of Employee's Primary Worksite:	Class/Occupation	Date of Hire	Annual Salary	Employment Status: ☐ Active Full-Time ☐ Active Part-Time
This change is due to: (check all that apply) ___Change in Coverage Amount ___Late Entrant* ___ Initial Eligibility Following Hire ___Add Dependent Coverage ___Other: _____				Effective Date of Coverage or Change:

**A late entrant is an individual who is first enrolling for coverage after the first available opportunity.*

Employee Information

Employee Name *(last, first, middle initial)*	☐ Female ☐ Male	Date of Birth / /	Social Security #	Employee I.D. #
Employee Address *(street address, city, state, zip code)*			Telephone Work ( ) Home ( )	

Employee Coverage

Portable Life	Guaranteed Issue (GI) Limit = $35,000. When you are first eligible for Portable Life coverage, you can elect up to the GI Limit without proof of good health. Total Portable Life coverage up to $200,000, not to exceed 5 times your basic annual earnings, is available if you complete a Portable Proof of Good Health form and ReliaStar Life approves it.
Portable Life Election	I currently have Portable Life coverage of: $_____. I am applying for additional Portable Life coverage of: $_____. *($5,000 increments)* Total Portable Life coverage (current plus additional): $_____.
Portable AD&D Election	☐ Amount equal to Portable Life insurance coverage up to $200,000. ☐ Waive

Beneficiary Information *Designate your beneficiary(ies) below.*

Name of Beneficiary *(last name, first, middle initial)*	Relationship to Employee	Benefit % *(MUST total 100%)*

Dependent Coverage

Dependent Life Insurance	Either you or your spouse may cover your dependent child(ren), but not both. When you are initially eligible for dependent coverage, you can elect it without proof of good health. At all other times, a Portable Proof of Good Health form must be completed for your child(ren) and ReliaStar Life must approve it. Child(ren) 14 days to 6 months are eligible for $100.
Dependent Life Insurance Election	☐ $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. ☐ Waive
Dependent AD&D Election	☐ Amount equal to dependent life coverage. ☐ Waive

Note: The covered parent is the beneficiary for any dependent child(ren) insurance coverage.

(SEE OTHER SIDE)

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages 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 my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee's Signature	Date Signed / /

FOR EMPLOYER/PLAN SPONSOR USE ONLY

COVERAGE	LIFE	AD&D	CHILD LIFE	CHILD AD&D
ACCOUNT				
CLASS				
AMOUNT				
EFF. DATE				