

**Voluntary Life Insurance and Voluntary LTD
Enrollment and Change Form**

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT	Your Name (Last, First, Middle)		Group Name Fayette County Public Schools		Group Number(s) 148212	
	Your Address		City		State	ZIP
	Your Soc. Sec. No.	Date of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation
	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr		Pay Periods per Year: <input type="checkbox"/> 18 <input type="checkbox"/> 24			
	<input type="checkbox"/> New Application		<input type="checkbox"/> Change Application			
VOLUNTARY LIFE	<i>Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.</i>					
	<p>Voluntary Life <input type="checkbox"/> Voluntary Life with AD&D Your requested amount \$ _____ Cost per Pay Period \$ _____</p> <p>Dependents Life Insurance <input type="checkbox"/> Voluntary Spouse Life with AD&D Spouse requested amount \$ _____ Cost per Pay Period \$ _____</p> <p><i>You may elect to insure your eligible Children under one of the following options:</i> <input type="checkbox"/> \$5,000 Child Life <input type="checkbox"/> \$10,000 Child Life Cost per Pay Period \$ _____</p>					
VOLUNTARY LTD	<i>Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.</i>					
	<p>Long Term Disability <input type="checkbox"/> Your Choice/Educator Options Refer to the enrollment materials provided (Coverage Highlights and Booklet), when completing the following: 1. Maximum Benefit Period (<i>choose one</i>): <input type="checkbox"/> Two Years <input type="checkbox"/> To Social Security Normal Retirement Age (SSNRA) 2. Monthly Disability Benefit: \$ _____ 3. Benefit Waiting Period (in days): _____ 4. Cost per Pay Period: \$ _____</p>					
BENEFICIARY	<i>This designation applies to Life Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.</i>					
	Primary - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
	Contingent - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
CHANGE	Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.					
	<input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent		<input type="checkbox"/> Name Change		<input type="checkbox"/> Beneficiary Change	
Date of add/delete _____		Former name _____		<input type="checkbox"/> Other _____		
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. If not electing Your Choice/Educator Options Group Voluntary LTD coverage, I understand that if I want to apply later, I must wait until my employer holds an annual enrollment.					
	Member/Employee Signature				Date (Mo/Day/Yr)	
Human Resources Department - Complete this section. Retain form for your records.						
Dvsn ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.			

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 any 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.