



University of South Alabama – Policy 947758

Life Insurance Enrollment and Change Form

Please type or print and complete all sections Pay Status: Biweekly Monthly

Employee Name (last, first, middle) Date of Birth Social Security No.

Basic Life Insurance Name Change To Single To Family

Additional Life Insurance coverage, Guarantee Issue (Employee paid)

1X BASIC - Employee \$25,000 - Spouse \$10,000 - Child

Dependent Information

List your spouse and all eligible dependent children

Name of Spouse: Date of Birth:

Table with 3 columns: Names of eligible dependents children, Date of Birth, Student?*

*Children age 19 or more must meet student eligibility requirements

Basic Life Insurance Primary Beneficiary Designation

(last name, first, initial) % Relationship

Basic Life Insurance Contingent Beneficiary Designation

(last name, first, initial) % Relationship

Additional Voluntary Life Insurance Primary Beneficiary Designation (if elected)

(last name, first, initial) % Relationship

Additional Voluntary Life Insurance Contingent Beneficiary Designation (if applicable)

(last name, first, initial) % Relationship

I wish to make the choices indicated on this form. If electing additional 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. Unless otherwise provided herein, if two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries surviving the insured. If no beneficiary has been designated, any proceeds will be payable as provided by the Group Policy. I further agree that my electronic signature is the legal equivalent of my manual signature on this form.

Member/Employee Signature: Date: