Group Life Insurance Enrollment Worksheet

EMPLOYER NAME: Youngstown State University

LIFE POLICY NUMBER: 34696
AD&D POLICY NUMBER: 34701

1. Please complete Group Life Evidence of Insurability for coverage that is not guaranteed.
2. Return completed and signed form to your Benefits Office.

A. EMPLOYEE INFORMATION

First Name	Middle Initial	Last Name		
Street Address		City	State	Zip Code
Date of Birth (Month, Day, Year)	Social Security Number	Date of Employment	Salary	Gender ☐ Male ☐ Female

B. BASIC LIFE – Eligible for 2.5 x base salary with a maximum of $250,000

Amount $ _____ Effective Date: _____

C. SUPPLEMENTAL LIFE

Employee
Current Amount $_____ ☐Increase ☐Decrease Amount $_____ Grand Total $_____ Effective Date _____

Spouse
Current Amount $_____ ☐Increase ☐Decrease Amount $_____ Grand Total $_____ Effective Date _____

Child
Current Amount $_____ ☐Increase ☐Decrease Amount $_____ Grand Total $_____ Effective Date _____

D. SPOUSE INFORMATION

First Name	Middle Initial	Last Name	
Date of Birth (Month, Day, Year)	Is your spouse also an employee covered under this plan? ☐ Yes ☐ No		Gender ☐ Male ☐ Female

E. VOLUNTARY AD&D

Voluntary AD&D Type (Check one) ☐ Employee Only ☐ Employee + Family

Current Amount $_____ ☐Increase ☐Decrease Amount $_____ Grand Total $_____ Effective Date _____

F. CHILDREN INFORMATION – (List names and date of birth for your eligible children)

G. AUTHORIZATION

I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for supplemental insurance coverage.

Employee Signature	Daytime Telephone Number	Evening Telephone Number	Date Signed