



REQUEST FOR GROUP LIFE INSURANCE

Reason for Form: New Hire Open Enrollment* (requires a Medical History Form for any new, or change in, coverage)
 Other Qualifying Event (please explain) _____

Type of Open Enrollment or Qualifying Event Request: NEW* INCREASE* DECREASE DEPENDENT ADDITION*

*Requires a Medical History Form for each individual

APPLICANT INFORMATION

Name: _____

Date of Birth: _____

SSN: _____

Date of Hire: _____

Current Address: _____

City _____

State: _____

Zip Code: _____

UVM Annual Salary: _____

Check here if your spouse is a UVM employee - NAME: _____

EMPLOYEE COVERAGE

In accordance with the terms of the Group Life Insurance Policy issued to my employer by Standard Life Insurance Company, I hereby request the following coverage:

Basic Life Insurance Coverage (Choose one or choose from the supplemental coverage)

\$10,000 (provided by UVM at no cost to the employee) \$50,000 2x Annual Base Salary

Supplemental Life Insurance Coverage Request (Requires a medical history form)

3x Annual Base Salary 4x Annual Base Salary 5x Annual Base Salary 6x Annual Base Salary 7x Annual Base Salary

SPOUSAL AND CHILD DEPENDENT COVERAGE

(Available if the employee chooses coverage over \$10,000): Spousal Insurance Request of \$50k or more requires a medical history form and approval by The Standard Insurance Company) **NOTE: Newborn dependent coverage may not start until the dependent is discharged from the hospital and at a minimum of 14 days after birth, whichever is later.**

Spousal Coverage: None \$20,000 1/2 Employee Coverage

Spouse's Name (IF choosing coverage): _____

Spouse's Date of Birth: _____

Dependent Child(ren) Coverage (Only under the age of 26 are eligible) None **OR** \$10,000 per child

Child's Name (if choosing coverage): _____

Date of Birth: _____

Child's Name (if choosing coverage): _____

Date of Birth: _____

Child's Name (if choosing coverage): _____

Date of Birth: _____

BENEFICIARY

A Primary Beneficiary is Required and a Contingent Beneficiary is Strongly Encouraged
(For Spouse/Dependent Insurance, the employee is automatically the beneficiary)

Primary Beneficiary Name: _____

Address: _____

City, State & Zip Code: _____

Contingent Beneficiary Name: _____

Address: _____

City, State & Zip Code: _____

I authorize the proper deductions from my earnings as my contribution toward the cost of the insurance I have elected above. Also, I understand that evidence of insurability satisfactory to The Standard Life Insurance Company will be required at my own expense if at some later date I wish to apply for the optional insurance to which I am now entitled to elect a higher insurance option. I designate the beneficiary shown to receive any death benefits which may become payable under the group policy.

Signature: _____

Date: _____

FOR HUMAN RESOURCES DEPARTMENT ONLY

Effective Date: _____

Group: #138236A