The University of Vermont

Empl ID: _____

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)

___ $6,000 (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*** $6,000): 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 ___ ½ 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:
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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***

updated August 2018