



# WESTERN MICHIGAN UNIVERSITY

Human Resources

1300 Seibert Administration Building, Mail Stop 5217  
Phone (269) 387-3620 Fax (269) 387-3441

INS

## Life Insurance Enrollment and Change Form

<b>Employee Information</b>					
<b>Effective Date</b>		<b>Date of Hire</b>	<b>Department</b>		<b>Employee ID No.</b>
<b>Last Name</b>		<b>First Name</b>		<b>MI</b>	<b>Date of Birth</b>
					<b>Gender</b> <input type="checkbox"/> M <input type="checkbox"/> F
<b>Email Address</b>			<b>Daytime Phone Number</b>		
<b>Enrollment Information – Employee Coverage</b>					
Type of Enrollment (check one):					
<input type="checkbox"/> Enroll upon hire		<input type="checkbox"/> Enroll through evidence of insurability		<input type="checkbox"/> Beneficiary change	
<input type="checkbox"/> Terminate coverage		<input type="checkbox"/> Reinstate – return from leave			
<b>Basic Life Insurance (automatic enrollment) – Please provide beneficiaries</b>					
Beneficiary Designation					
<b>Last Name</b>		<b>First name</b>	<b>MI</b>	<b>Change</b>	<b>Primary or Contingent</b>
					<b>Total Primary = 100%</b> <b>Contingent = 100%</b>
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
<input type="checkbox"/> <b>Additional 1 life insurance</b>					
<input type="checkbox"/> <b>Waive coverage</b>					
Beneficiary Designation					
<b>Last Name</b>		<b>First name</b>	<b>MI</b>	<b>Change</b>	<b>Primary or Contingent</b>
					<b>Total Primary = 100%</b> <b>Contingent = 100%</b>
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
<input type="checkbox"/> <b>Additional 2 life insurance</b>					
<input type="checkbox"/> <b>Waive coverage</b>					
Please select amount: <input type="checkbox"/> 1x or <input type="checkbox"/> 2x annual base salary					
Beneficiary Designation					
<b>Last Name</b>		<b>First name</b>	<b>MI</b>	<b>Change</b>	<b>Primary or Contingent</b>
					<b>Total Primary = 100%</b> <b>Contingent = 100%</b>
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
				<input type="checkbox"/> Add <input type="checkbox"/> Remove	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent

**Please complete page 2 – beneficiary information, employee signature and date**

<b>Beneficiary Information</b>					
Please complete for each beneficiary listed on page 1					
Last Name	First Name	MI	Phone Number	Date of Birth	Relationship
Address			City	State	Zip Code
Last Name	First Name	MI	Phone Number	Date of Birth	Relationship
Address			City	State	Zip Code
Last Name	First Name	MI	Phone Number	Date of Birth	Relationship
Address			City	State	Zip Code
Last Name	First Name	MI	Phone Number	Date of Birth	Relationship
Address			City	State	Zip Code
Last Name	First Name	MI	Phone Number	Date of Birth	Relationship
Address			City	State	Zip Code
<ul style="list-style-type: none"> <li>• I wish to apply for the insurance indicated above, or authorize the changes noted on reverse side.</li> <li>• 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 costs change.</li> <li>• I understand that if I waive any of these insurance coverages, and at a later date wish to request such coverage for myself, I will be required to furnish, which may be at my own expense, evidence of insurability satisfactory to the insurance carrier.</li> <li>• To the best of my knowledge and belief, the information I have provided is complete and correct.</li> </ul>					
Employee Signature				Date	
<b>HR USE ONLY</b>	HRA	Update ABBR Panel	Employee Group	Deduction Begin Date	