Group: GP-72157

Oakland University
Life Enrollment / Waiver Form

A. Enrollment Information (Note: You are required to complete all sections of this form.)

	Requested Employee Coverage	Requested Dependent Coverage	Waiver of Coverage
1. Effective Date_____ Hire Date_____ ☐ **Faculty (2A-CTGRP; 2-CTGRP)** ☐ **Staff (3A-CTGRP; 3-CTGRP)**	☐ Basic Life ☐ Supplemental Life ☐ Supplemental AD&D	☐ Dependent Life ☐ Dependent AD&D	☐ Myself (and all eligible dependents, if applicable) ☐ My eligible dependent spouse and children only ☐ My eligible dependent spouse only ☐ My eligible dependent children only

B. Employee Information – Please Print all Information

1. Employee Social Security Number - -	2. Employee Name (Last, First, M.I.)	3. Birthdate (MM/DD/YYYY) / /	4. Sex ☐ M ☐ F	5. Telephone Numbers HOME ( ) - WORK ( ) -
6. Employee Home Address (Number, Street, Apt. No., City, State, ZIP Code)		7. Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed	8. Employee Annual Earnings $	9. Occupation/Title

10. Employee Coverage Amounts (Based on the requirements of your Plan, you may have to submit evidence of good health.)

Basic Life Amount (1xAnnual Salary)	Supplemental Life Amount	Supplemental AD&D Amount
$	$ ☐ Waive	$ ☐ Waive

C. Covered Dependents.

☐ I have no eligible dependents. Skip to D. ☐ I have eligible dependents. Complete the section below.

Dependent Name (First, Middle Initial, last)	Social Security Number (If dependent has no SSN, write "None")	Relationship to Employee	Birth Date MM / DD / YYYY	Full Time Student Yes No	Dependent Life Amt	Waive Coverage	Dependent AD&D Amt	Waive Coverage
	- -		/ /	☐ ☐		☐		☐
	- -		/ /	☐ ☐		☐		☐
	- -		/ /	☐ ☐		☐		☐
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	- -		/ /	☐ ☐		☐		☐
	- -		/ /	☐ ☐		☐		☐

D. Beneficiary Designation (Please select one)

☐ I am waiving all Life and AD&D coverage. Skip to E.
☐ I have elected Life and/or AD&D coverage. Complete the sections(s) below.
Note: If more than one beneficiary is named, beneficiaries will share equally unless alternative percentages are specified.

TURN PAGE OVER AND COMPLETE OTHER SIDE

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Beneficiary Designation, continued
Dependent coverage Beneficiary is always the Employee.

1. Basic Life

Beneficiary Type	Beneficiary name (First, Middle, Last)	Address	Social Security Number	Relationship to Employee	%, if not equal
□ Primary			- -		
□ Primary □ Contingent			- -		
□ Primary □ Contingent			- -		
□ Primary □ Contingent			- -		

□ **Check here if beneficiary designation above is the same for all Life and AD&D coverage. Go to E.**

2. Supplemental Life (Use space on bottom right for additional names.)

Beneficiary Type	Beneficiary name (First, Middle, Last)	Address	Social Security Number	Relationship to Employee	%, if not equal
□ Primary			- -		
□ Primary □ Contingent			- -		
□ Primary □ Contingent			- -		
□ Primary □ Contingent			- -		

3. Supplemental AD&D (Use space on bottom right for additional names.)

Beneficiary Type	Beneficiary name (First, Middle, Last)	Address	Social Security Number	Relationship to Employee	%, if not equal
□ Primary			- -		
□ Primary □ Contingent			- -		
□ Primary □ Contingent			- -		
□ Primary □ Contingent			- -		

E. Certification – Signature Required

I represent that the information I have provided in this Enrollment/Waiver form is complete, true and accurate, to the best of my knowledge. If I am waiving coverage, I understand that if I wish to apply for waived coverage in the future, I may be considered a late enrollee and Evidence of Insurability will be required.

	Date
1. Employee Signature *(Required)* **X**	