|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NEW ENROLLMENT  REFUSAL  CHANGE  CANCELLATION Reason for Change: | | | | | | | | | | | |
| EMPLOYMENT DATE: | | | | | | | | | | | |
| **SUBSCRIBERS NAME (Last, First, MI)** | | **SOCIAL SECURITY NUMBER** | | | | | | **EMPLID** | | | BIRTHDATE |
| **,** | |  | | | | | |  | | |  |
|  | | | | | | | | | | | |
| I hereby designate the following as my beneficiaries under the group life insurance plan provided by the Missouri State Highway Commission; and reserve the right to change or revoke such designation at any time. | | | | | | | | | | | |
| PRIMARY BENEFICIARY DESIGNATION | | | | | | | | | | | |
| **NAME (1)** | **PHONE NUMBER** | | | SOCIAL SECURITY NUMBER | | **RELATIONSHIP** | | | | | **PERCENT OF BENEFIT** |
|  |  | | |  | |  | | | | | % |
| HOME ADDRESS (1) | | | | CITY | | | | | STATE | | ZIP |
|  | | | |  | | | | |  | |  |
| NAME (2) | **PHONE NUMBER** | | | **SOCIAL SECURITY NUMBER** | | **RELATIONSHIP** | | | | | **PERCENT OF BENEFIT** |
|  |  | | |  | |  | | | | | % |
| HOME ADDRESS (2) | | | | CITY | | | | | STATE | | ZIP |
|  | | | |  | | | | |  | |  |
| **NAME (3)** | **PHONE NUMBER** | | | SOCIAL SECURITY NUMBER | | **RELATIONSHIP** | | | | | **PERCENT OF BENEFIT** |
|  |  | | |  | |  | | | | | % |
| HOME ADDRESS (3) | | | | CITY | | | | | STATE | | ZIP |
|  | | | |  | | | | |  | |  |
| **NAME (4)** | **PHONE NUMBER** | | | SOCIAL SECURITY NUMBER | | **RELATIONSHIP** | | | | | **PERCENT OF BENEFIT** |
|  |  | | |  | |  | | | | | % |
| HOME ADDRESS (4) | | | | CITY | | | | | STATE | | ZIP |
|  | | | |  | | | | |  | |  |
| TOTAL FOR PRIMARY BENEFICIARY (MUST BE 100%) | | | | | | | | | | | TOTAL |
|  | | | | | | | | | | | % |
| CONTINGENT BENEFICIARY DESIGNATION | | | | | | | | | | | |
| **NAME (1)** | **PHONE NUMBER** | | | SOCIAL SECURITY NUMBER | | **RELATIONSHIP** | | | | | **PERCENT OF BENEFIT** |
|  |  | | |  | |  | | | | | % |
| HOME ADDRESS (1) | | | | CITY | | | | | STATE | | ZIP |
|  | | | |  | | | | |  | |  |
| NAME (2) | **PHONE NUMBER** | | | **SOCIAL SECURITY NUMBER** | | **RELATIONSHIP** | | | | | **PERCENT OF BENEFIT** |
|  |  | | |  | |  | | | | | % |
| HOME ADDRESS (2) | | | | CITY | | | | | STATE | | ZIP |
|  | | | |  | | | | |  | |  |
| **NAME (3)** | **PHONE NUMBER** | | | SOCIAL SECURITY NUMBER | | **RELATIONSHIP** | | | | | **PERCENT OF BENEFIT** |
|  |  | | |  | |  | | | | | % |
| HOME ADDRESS (3) | | | | CITY | | | | | STATE | | ZIP |
|  | | | |  | | | | |  | |  |
| **NAME (4)** | **PHONE NUMBER** | | | SOCIAL SECURITY NUMBER | | **RELATIONSHIP** | | | | | **PERCENT OF BENEFIT** |
|  |  | | |  | |  | | | | | % |
| HOME ADDRESS (4) | | | | CITY | | | | | STATE | | ZIP |
|  | | | |  | | | | |  | |  |
| TOTAL FOR CONTINGENT BENEFICIARY (MUST EQUAL 100%) | | | | | | | | | | | TOTAL |
|  | | | | | | | | | | | % |
| Page P Page 1 of 2 | | | | | | | | | | | |
|  | | | | | | | | | | | |
| SUBSCRIBER’S NAME (Last, First, MI) | | | SOCIAL SECURITY NUMBER | | | | EMPLID | | | BIRTHDATE | |
| , | | |  | | | |  | | |  | |
|  | | | | | | | | | | | |
|  | | | | | | | | | | | |
| Estate, Trust, or Charity/Organization:  Primary  Contingent Proceeds assigned: \_\_   % | | | | | | | | | | | |
| **NAME OF ENTITY** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| CONTACT/ TRUSTEE NAME | | | | | | PHONE NUMBER | | | | | |
|  | | | | | |  | | | | | |
| HOME ADDRESS (1) | | | | CITY | | | | | STATE | | ZIP |
|  | | | |  | | | | |  | |  |
| **ENROLLMENT ACCEPTANCE** | | | | | | | | | | | |
| I acknowledge that if I refuse or cancel this life insurance plan, the State Contribution will not be applied to reduce my medical plan cost or paid to me directly. I also understand by refusing this plan, I will be required to provide evidence of insurability acceptable to the insurance carrier in the future. I understand I have 31 days from my employment date to change my decision and participate in the Plan without evidence of insurability. By signing below, I hereby revoke any previous designations; and I designate the person, people or entity named herein as beneficiaries. | | | | | | | | | | | |
| **Subscriber’s signature** | | | | | Date | | | | | | |
| **Insurance Representative’s Signature** | | | | | Date | | | | | Div/Dist/Troop | |
| REFUSAL (complete when employee refuses to sign) | | | | | | | | | | | |
| I certify that the benefits of the plan mentioned in this form were thoroughly explained to the employee and he/she has declined to participate; and refused to sign the above statement. | | | | | | | | | | | |
| **Insurance Representative’s Signature** | | | | | Date | | | | | Div/Dist/Troop | |

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