|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| NEW ENROLLMENT  REFUSAL  CHANGE  CANCELLATION **EFFECTIVE DATE:**    REASON FOR CHANGE OR CANCELLATION: | | | | | | | | | | | | |
| **SUBSCRIBERS NAME (Last, First, MI)** | | | | | | | **SOCIAL SECURITY NUMBER** | | | | | **EMPLID** |
| **,** | | | | | | |  | | | | |  |
| Birthdate (MM/DD/YYYY) | | | **Age** | | **Retirement Plan**  Closed Plan  Y2000 Plan  2011 Tier Plan | | | | | | | Dist/Div/Troop |
| RETIREMENT PLAN OPTIONS | | | | | | | | | | | | |
| **Closed Plan** – Employees retiring under the Closed Plan may not retain more than $60,000. If the Basic (State Paid) Life Insurance coverage and Optional Group Life Insurance coverage amounts carried as an active employee do not equal $60,000, and the retiree wishes to carry $60,000, evidence of insurability must be provided and approved prior to retirement. The retiree may elect Optional Group Life Insurance coverage in the amount of Basic (State Paid) Life Insurance coverage, if only enrolled in Basic (State Paid) Life Insurance coverage as an active employee.  **Year 2000 Plan / 2011 Tier Plan** – Employees retiring under the “Rule of 80” (at least age 50 with age + service years equaling 80) in the Year 2000 Plan or the 2011 Tier Plan may retain the same amount of Optional Group Life Insurance coverage that was in effect during the month prior to leaving state employment. When retirees reach age 62, they can retain insurance in an amount no greater than the amount in effect during the month prior to attaining age 62, not to exceed $60,000. | | | | | | | | | | | | |
| COVERAGE ELECTIONS | | | | | | | | | | | | |
|  |  | | | | | | | **Amount of Optional Life Insurance Elected** | | **Rate/thousand for age bracket** | | **Amount of deduction** |
| Subscriber | | **Maximum Available $** | | | | | | **$** | | **X** | | **$** **0.00** | |
| Spouse | | Maximum Available $ | | | | | | $ | | X 0.000 | | $ 0.00 | |
| MONTHLY PREMIUM | | | | | | | | | | | | **$** **0.00** | |
| SPOUSE INFORMATION | | | | | | | | | | | | |
| **Social Security** | | | | **Name** | | | | | **Birthdate** | | | **Marriage Date** |
|  | | | | **,** | | | | |  | | |  |
| COMPLETE THIS PORTION FOR CANCELLATION OR REFUSAL | | | | | | | | | | | | |
| **Cancellation**  **Refusal**  **Refusal to Sign** | | | | I have elected to cancel my Optional Group Life Insurance. I understand that if I cancel this plan, I shall not be eligible to re-enroll in the future.  I hereby acknowledge I have been given an opportunity to participate in the Optional Group Life Insurance. By refusing this plan at Retirement, I understand that I will not be able to re-enroll in the future.  I certify that the benefits of the plan were thoroughly explained to the subscriber and he/she has declined to participate; and also refused to sign to the above statement. | | | | | | | | |
| ENROLLMENT ACCEPTANCE | | | | | | | | | | | | |
| I hereby accept the Optional Group Life Insurance in the amount indicated above and authorize, until revoked by me in writing, the deduction from my regular monthly retired pay an amount sufficient to cover the premium under said Optional Life Insurance Contract. | | | | | | | | | | | | |
| **Subscriber’s signature** | | | | | | Date | | | | | | |
| **Insurance Representative’s signature** | | | | | | **Date** | | | | | **Dist/Div/Troop** | |
| **REFUSAL (complete when member refuses to sign)** | | | | | | | | | | | | |
| I certify that the benefits of the plan mentioned on this form were thoroughly explained to the member and he/she has declined to participate; and also refused to sign the above statement. | | | | | | | | | | | | |
| **Insurance Representative’s signature** | | | | | | **Date** | | | | | | |

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|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **SUBSCRIBERS NAME (Last, First, MI)** | | **SOCIAL SECURITY NUMBER** | | | **EMPLID** | | | BIRTH DATE |
| **,** | |  | | |  | | |  |
| 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 |
|  | | | | | | | | % |
| Estate, Trust or Charity/Organization:  Primary  Contingent Proceeds assigned: \_\_   % | | | | | | | | |
| **NAME OF ENTITY** | | | | | | | | |
|  | | | | | | | | |
| CONTACT/ TRUSTEE NAME | | | | | | PHONE NUMBER | | |
|  | | | | | |  | | |
| HOME ADDRESS (1) | | | CITY | | | | STATE | ZIP |
|  | | |  | | | |  |  |
| 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 | | | | |

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