MISSOURI DEPARTMENT OF TRANSPORTATION AND MISSOURI STATE HIGHWAY PATROL

# OPTIONAL GROUP LIFE INSURANCE ENROLLMENT FORM

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| **[ ]**  NEW ENROLLMENT **[ ]**  REFUSAL **[ ]**  CHANGE **[ ]**  CANCELLATION **EFFECTIVE DATE:**  REASON FOR CHANGE OR CANCELLATION:   |
| SUBSCRIBERS NAME (Last, First, MI) | SOCIAL SECURITY | EMPLID | BIRTH DATE |
| **,** |       |       |       |
| COVERAGE ELECTIONS |
| **ABBR** (Annual Benefit Base Rate) **$**\_\_\_\_\_\_\_ **Maximum Available $**\_\_\_\_\_\_\_ |
|  |  | **Amount of Optional Life Insurance Elected** | **Rate/thousand for age bracket** | **Amount of deduction** |
| Subscriber | $15,000 minimum, $800,000 maximumMultiples of 1-6 times ABBR or flat dollar amount. **Multiple chosen** *(type in 1,2,3,4,5,6)*  | $  | X  = | **$** **0.0** |
| **Spouse** | Minimum of $15,000. Medical history required for coverage in excess of $15,000. Can select $5,000 increments not to exceed $100,000. | $  | X **0** = | **$** **0.0** |
| **Child(ren)** | $15,000 coverage per child | N/A | N/A | **$** **0.00** |
|  |  | Total Premium | **$** **$0.00** |
| SPOUSE AND CHILDREN INFORMATION |
| **Social Security**  | **Name** | **Relationship** | **Birth Date** | **Marriage Date** |
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| BENEFICIARY DESIGNATION |
| Primary Beneficiary | **1** | 2      | **3** |
| Relationship | 1      | 2      | 3      |
| Contingent Beneficiary | **1** | 2      | 3      |
| Relationship | **1** | 2      | **3** |
| Contingent Beneficiary | **4** | **5** | **6** |
| Relationship | **4** | **5** | **6** |
| ENROLLMENT ACCEPTANCE |
| I hereby authorize the selections made above and the deduction necessary to pay for the coverage elected and certify the above named are my spouse and dependent child(ren). I understand all elections will be effective in accordance with the terms of the group member policy and amendments hereto. I 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. |
| **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 on this form were thoroughly explained to the employee and he/she has declined to participate and also refused to sign the above statement. |
| Insurance Representative’s signature | Date |