MISSOURI DEPARTMENT OF TRANSPORTATION AND MISSOURI STATE HIGHWAY PATROL

# OPTIONAL GROUP LIFE INSURANCE ENROLLMENT FORM

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 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 maximum  Multiples 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 | | | | | | | | | |