

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

Your Name (Last, First, Middle)		Group Name Furman University	Group Number(s) 140090	
Your Address		City	State	ZIP
Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation

Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.

Life Insurance
 Life with AD&D

Additional/Optional Life & AD&D
 You must elect Life with AD&D to be eligible to elect Additional/Optional Life:
 Additional/Optional Life & AD&D Your requested amount \$ _____

Dependents Life Insurance
 Spouse/Child(ren)

This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.

Add Dependent
 Delete Dependent
 Name Change
 Beneficiary Change
 Date of add/delete _____
 Former name _____
 Other _____

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required	Date (Mo/Day/Yr)
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Human Resources Department - Complete this section. Retain form for your records.

Dvsn ID	Billing Cat	Date of Hire/Rehire	Hrs. Worked Per Wk	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr
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