

Oakland University Life Enrollment / Waiver Form

A. Enrollment Information (Note: You are required to complete all sections of this form.)

1. Effective Date _____ Hire Date _____ <input type="checkbox"/> Faculty <input type="checkbox"/> Staff	Requested Employee Coverage <input type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental Life <input type="checkbox"/> Supplemental AD&D	Requested Dependent Coverage <input type="checkbox"/> Dependent Life <input type="checkbox"/> Dependent AD&D	Waiver of Coverage <input type="checkbox"/> Myself (and all eligible dependents, if applicable) <input type="checkbox"/> My eligible dependent spouse and children only <input type="checkbox"/> My eligible dependent spouse only <input type="checkbox"/> My eligible dependent children only
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B. Employee Information – Please Print all Information

1. Employee Social Security Number - -	2. Employee Name (Last, First, M.I.)	3. Birthdate (MM/DD/YYYY) / /	4. Sex <input type="checkbox"/> M <input type="checkbox"/> F	5. Telephone Numbers HOME () - WORK () -
6. Employee Home Address (Number, Street, Apt. No., City, State, ZIP Code)		7. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed	8. Employee Annual Earnings \$	9. Occupation/Title

10. Employee Coverage Amounts (Based on the requirements of your Plan, you may have to submit evidence of good health.)

Basic Life Amount (1xAnnual Salary) \$	Supplemental Life Amount \$ <input type="checkbox"/> Waive	Supplemental AD&D Amount \$ <input type="checkbox"/> Waive
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C. Covered Dependents.

I have no eligible dependents. Skip to D. I have eligible dependents. Complete the section below.

Dependent Name (First, Middle Initial, last)	Social Security Number (If dependent has no SSN, write "None")	Relationship to Employee	Birth Date MM / DD / YYYY	Full Time Student Yes No	Dependent Life Amt	Waive Coverage	Dependent AD&D Amt	Waive Coverage
	- -		/ /	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
	- -		/ /	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
	- -		/ /	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
	- -		/ /	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
	- -		/ /	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>
	- -		/ /	<input type="checkbox"/> <input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>

D. Beneficiary Designation (Please select one)

I am waiving all Life and AD&D coverage. Skip to E.
 I have elected Life and/or AD&D coverage. Complete the sections(s) below.

Note: If more than one beneficiary is named, beneficiaries will share equally unless alternative percentages are specified.

TURN PAGE OVER AND COMPLETE OTHER SIDE

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Beneficiary Designation, continued

Dependent coverage Beneficiary is always the Employee.

1. Basic Life

Beneficiary Type	Beneficiary name (First, Middle, Last)	Address	Social Security Number	Relationship to Employee	%, if not equal
<input type="checkbox"/> Primary			- -		
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			- -		
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			- -		
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			- -		

Check here if beneficiary designation above is the same for all Life and AD&D coverage. Go to E.

2. Supplemental Life (Use space on bottom right for additional names.)

Beneficiary Type	Beneficiary name (First, Middle, Last)	Address	Social Security Number	Relationship to Employee	%, if not equal
<input type="checkbox"/> Primary			- -		
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			- -		
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			- -		
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			- -		

3. Supplemental AD&D (Use space on bottom right for additional names.)

Beneficiary Type	Beneficiary name (First, Middle, Last)	Address	Social Security Number	Relationship to Employee	%, if not equal
<input type="checkbox"/> Primary			- -		
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			- -		
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			- -		
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent			- -		

E. Certification – Signature Required

I represent that the information I have provided in this Enrollment/Waiver form is complete, true and accurate, to the best of my knowledge. If I am waiving coverage, I understand that if I wish to apply for waived coverage in the future, I may be considered a late enrollee and Evidence of Insurability will be required.

Employee Signature <i>(Required)</i> X	Date
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