Oakland University
Life Enrollment / Waiver Form

Employees Eligible for
EXECUTIVE LIFE

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

1. Effective Date_____ Hire Date _____	**Requested Employee Coverage** ☐ Basic Life-Executive ☐ Supplemental Life ☐ Collective Life ☐ Supplemental AD&D	**Requested Dependent Coverage** ☐ Dependent Life ☐ Dependent AD&D	**Waiver of Coverage** ☐ Myself (and all eligible dependents, if applicable) ☐ My eligible dependent spouse and children only ☐ My eligible dependent spouse only ☐ My eligible dependent children only

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 ☐ M ☐ F	5. Telephone Numbers HOME ( ) - WORK ( ) -
6. Employee Home Address (Number, Street, Apt. No., City, State, ZIP Code)		7. Marital Status ☐ Single ☐ Divorced ☐ Married ☐ 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 – Executive Amount (1X Annual Salary+ $40,000)	Supplemental Life Amount	Supplemental AD&D Amount
$ *Also eligible for Collective Life Amount according to schedule.*	$ ☐ Waive	$ ☐ Waive

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
	- -		/ /	☐ ☐		☐		☐
	- -		/ /	☐ ☐		☐		☐
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	- -		/ /	☐ ☐		☐		☐

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: **Dependent coverage Beneficiary is always the Employee.**

1. Basic Life - Executive

Beneficiary Type	Beneficiary name (First, Middle, Last)	Address	Social Security Number	Relationship to Employee	%, if not equal
□ Primary			- -		
□ Primary □ Contingent			- -		
□ Primary □ Contingent			- -		
□ Primary □ Contingent			- -		

□ **Check here if beneficiary designation above is the same for all Life and AD&D coverage.**

2. Collective 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
□ Primary			- -		
□ Primary □ Contingent			- -		
□ Primary □ Contingent			- -		

3. 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
□ Primary			- -		
□ Primary □ Contingent			- -		
□ Primary □ Contingent			- -		

4. 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
□ Primary			- -		
□ Primary □ Contingent			- -		
□ Primary □ Contingent			- -		

Certification – Signature Required

I represent that the information I have provided in this Beneficiary Designation Change 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 *(Required)*	Date