KENTUCKY PERSONNEL CABINET | Department of Employee Insurance

LIFE INSURANCE ENROLLMENT AND CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Group Customer/Employer	Group Customer #	Report #	Sub Code	Branch
Commonwealth of Kentucky	**235782**	**235782**	**0001**	**0001**

Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)

Company Number	Company Name (Agency, Health Dept., School Board)	Organizational Unit Number	Cost Center Number

☐ **Termination**: Date Employment Ends _____ Date Life Insurance Terminates _____

Reason: ☐ Resigned ☐ Retired ☐ LWOP ☐ Death ☐ Military Leave ☐ Other_____

☐ **Reinstate Coverage**: Date Returned to Work _____ Date Insurance Effective _____

Reason: ☐ LWOP ☐ Military Leave ☐ Other_____

☐ **Transfer or Summer Transfer** To be completed by the NEW company

Prior Company Number:	New Company Number:
Last Day Worked at Prior Company:	Date Hired at New Company:
Coverage End Date at Prior Company:	Coverage Begin Date at New Company:

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)

Name (First, Middle, Last)	Social Security #	☐ Male ☐ Female

Address (Street, City, State, Zip Code)	Date of Birth (MM/DD/YYYY)

Work Phone # / Home/Cell Phone #	Email Address	☐ New Enrollment ☐ Change in Enrollment If due to a Qualifying Event, enter event date (MM/DD/YYYY)

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that no contributions are required for Basic Life and Basic AD&D. I understand that contributions are required for the benefits I select below.

▶ If you are enrolling after the initial enrollment period during mid-year elections, you must also complete a Statement of Health form.

Term Life Insurance

☒ Basic Life

☐ Supplemental/Optional Life

☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ $150,000

Dependent Spouse Life and Dependent Child Life

- ☐ Option 1 – Dependent Spouse Life $10,000; Dependent Child Life up to 6 months $2,500; Dependent Child Life 6 months to 26 years $5,000
- ☐ Option 2 – Dependent Spouse Life $20,000; Dependent Child Life up to 6 months $2,500; Dependent Child Life 6 months to 26 years $10,000
- ☐ Option 3 – Dependent Spouse Life $50,000; Dependent Child Life up to 6 months $2,500; Dependent Child Life 6 months to 26 years $10,000
- ☐ Option 4 – Dependent Spouse Life $10,000; Dependent Child Life up to 6 months $0; Dependent Child Life 6 months to 26 years $0
- ☐ Option 5 – Dependent Spouse Life $20,000; Dependent Child Life up to 6 months $0; Dependent Child Life 6 months to 26 years $0
- ☐ Option 6 – Dependent Spouse Life $50,000; Dependent Child Life up to 6 months $0; Dependent Child Life 6 months to 26 years $0
- ☐ Option 7 – Dependent Spouse Life $0; Dependent Child Life up to 6 months $2,500; Dependent Child Life 6 months to 26 years $5,000
- ☐ Option 8 – Dependent Spouse Life $0; Dependent Child Life up to 6 months $2,500; Dependent Child Life 6 months to 26 years $10,000

Accidental Death & Dismemberment (AD&D) Insurance

☒ Basic AD&D ☐ Supplemental/Optional AD&D

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to your Employer.

BENEFICIARY DESIGNATION FOR EMPLOYEE INSURANCE

☐ Check if this is a Beneficiary Change

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked.
I understand I have the right to change this designation at any time. I also understand that unless otherwise specified in the group insurance certificate, insurance due upon the death of a Dependent is payable to the Employee.

☐ Check if you need more space for additional beneficiaries and attach a separate page. Include all beneficiary information, and sign/date the page.

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Home Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			**TOTAL:**	100%

If all the primary beneficiary(ies) die before me, I designate as contingent beneficiary(ies):

Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Full Name (First, Middle, Last)	Social Security #	Date of Birth (Mo./Day/Yr.)	Relationship	Share %
Address (Street, City, State, Zip)			Phone #	
Payment will be made in equal shares or all to the survivor unless otherwise indicated.			**TOTAL:**	100%

DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given is true and complete to the best of my knowledge and belief.
2. I declare that I am actively at work on the date I am enrolling and, if I am enrolling for any contributory life insurance, that I am performing all the usual and customary duties of the job on a full-time basis. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. I understand that if I do not enroll for life coverage during the initial enrollment period, or if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
4. I authorize my employer to deduct the required contributions from my earnings for my coverage. This authorization applies to such coverage until I rescind it in writing.
5. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose.
6. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

Signature of Employee	Print Name	Date Signed (MM/DD/YYYY)
IC/HRG Signature	Print Name	Date Signed (MM/DD/YYYY)