TRUMBULL BOARD OF EDUCATION **Anthem Life Insurance Co.**

Basic Group Term Life and AD&D Enrollment Form

New Enrollment ☐ Beneficiary Change ☐ Address Change ☐ Name Change ☐ Amt Change ☐ Terminate ☐

SECTION I APPLICANT INFORMATION (please complete)

Full Name: _____ **Date:** _____

Last *First* *M.I.*

Address: _____

Street Address *City* *State* *ZIP Code*

Phone: _____ **Email:** _____

Date of Birth ___/___/___ **Age** _____ **Social Security No.:** ___-___-___ **Date of Hire:** ___/___/___

Section II BENEFIT SELECTION (for TBOE use only)

		YES	NO	
Basic Term Life and AD&D	**Accept**	☐	☐	**Benefit Amount: $**

Life Insurance replaces your income and helps your family survive after your death. The Basic Term Life and AD&D is paid for by the Trumbull Board of Education.

Effective Date ___/___/___ **Class** _____ **Hours Worked** _____ **GROUP # 800663E**

SECTION III BENEFICIARY INFORMATION (please designate at least one primary beneficiary)

It is important that your beneficiary designation is clear. It is also important that you name a primary beneficiary(ies) and contingent beneficiary(ies). If the beneficiary is not related to you by either blood or marriage, please insert the words 'not related' in the relationship box. If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in percentages, for example '33% to Mary Jones, Mother, and 67% to Edith Jones, Wife'.

PRIMARY BENEFICIARY:

Full Name		Relationship		DOB	/ /
Address					%

Full Name		Relationship		DOB	/ /
Address					%

CONTINGIENT BENEFICIARY:

Full Name		Relationship		DOB	/ /
Address					%

Full Name		Relationship		DOB	/ /
Address					%

Full Name		Relationship		DOB	/ /
Address					%

SECTION IV ELIGIBILITY AND AUTHORIZATION (please sign and date)

I have been given the opportunity to enroll in Trumbull Board of Education's benefit coverages. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to the insurer and understand my request for coverage may be denied. Current employees who did not previously enroll will be required to provide evidence of insurability.

Information in this application, including the Insurability questionnaire, is given to obtain insurance and the statements and answers are represented, to the best of my knowledge and belief to be true and complete. I understand that (a) the insurance applied for shall not take effect until the application is approved; and (b) all insurance is subject to the eligibility provisions of the policy; and (c) must be actively at work (as defined in the group policy) to be insured. If I am not actively at work on the date my coverage would become effective, my coverage will not begin until the day I return to work. I also understand that a pre-existing condition exclusion may apply to my coverage. If your answers on this application are incorrect or untrue, the carrier has the right to deny benefits or rescind your coverage.

Authorization to Release Information: I authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau (MIB) or any other organization , institution or person that has nay records of knowledge of me or my health to give Anthem Life Insurance Company or its reinsurer(s) any such information. This authorization is valid for 24 months from the date it is signed. I agree that a photocopy of this authorization shall be as valid as the original.

Employee Signature: _____ **Date:** _____