Group Life Insurance Enrollment Worksheet Self-administered

ACTIVE (BASIC W/MATCHING AD&D)

Rhode Island Interlocal Risk Management Trust (RIIRMT) **LIFE POLICY NUMBER: 8511750**

MEMBER NAME: East Greenwich School Department

Return completed and signed form to your Benefits Office

A. EMPLOYEE INFORMATION

First Name | Middle Initial | Last Name

Street Address	City	State	Zip Code

Date of Birth (Month, Day, Year)	Social Security Number	**Date of employment**	Gender □ Male □ Female

B. LIFE INSURANCE

Basic Life $_____

Includes Matching AD&D

Class:

50C: ☐
School Superintendent (1 x Salary) Maximum Benefit 250K

50D: ☐
School Administrators (60K)

Effective Date: _____

The 1st of the Month Following the Day You Become a Member (Date of Hire)

50E: ☐
School Custodians/Maintenance (40K)

Position:

_____

C. BENEFICIARY

PRIMARY BENEFICIARY(IES) – The person or persons named will receive the benefit.

Beneficiary Full Name/Trust	Date of birth/trust date	Tax ID (SSN or EIN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary Full Name/Trust	Date of birth/trust date	Tax ID (SSN or EIN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary Full Name/Trust	Date of birth/trust date	Tax ID (SSN or EIN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	

Total Primary Share Must Equal 100%

CONTINGENT BENEFICIARY(IES) – Receives a benefit ONLY if all primary beneficiaries are no longer living.

Beneficiary Full Name/Trust	Date of birth/trust date	Tax ID (SSN or EIN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary Full Name/Trust	Date of birth/trust date	Tax ID (SSN or EIN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	
Beneficiary Full Name/Trust	Date of birth/trust date	Tax ID (SSN or EIN)	Share %
Address (street, city, state, zip) and phone number		Relationship to insured	

Total Contingent Share Must Equal 100%

D. AUTHORIZATION

I authorize my employer to make these change(s). This beneficiary form revokes all prior designations.

Insured's Signature	Daytime Telephone Number	Evening Telephone Number	**Date Signed**