



**2020 Plan Year**

*Please do not staple or attach other documents to this form. Please complete and print all information. Use black or blue ink only.*

Application Type:     New Hire     Qualifying Event     Open Enrollment     Beneficiary Change

Company Number	Company Name (Specify name or Agency, School Board or Health Dept.)	Organizational Unit #	Cost Center #
Name (Last, First, MI)	SSN	Email	Birthdate
Mailing Address	Annual Salary	Hire Date	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
City, County, State, Zip	Work Telephone	Home Telephone	

- 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:    Resigned    Retired    LWOP    Death    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:

**A. Basic Life and Accidental Death and Dismemberment (AD&D) Insurance**

Eligible employees are insured at no cost to the employee for Basic Life and AD&D Insurance  
All Eligible Employees      \$20,000      Cost: (employer paid)

**B. Optional Life and Accidental Death and Dismemberment (AD&D) insurance (Select One Plan)**

I wish to  enroll\* in,  change\* to,  terminate the optional insurance plan checked below:

Age	<input type="checkbox"/> Option 1 \$5,000	<input type="checkbox"/> Option 2 \$10,000	<input type="checkbox"/> Option 3 \$25,000	<input type="checkbox"/> Option 4 \$50,000	<input type="checkbox"/> Option 5 \$100,000	<input type="checkbox"/> Option 6 \$150,000
Under age 40	\$1.10	\$2.22	\$5.52	\$11.04	\$22.08	\$33.12
Ages 40-59	\$2.76	\$5.52	\$13.80	\$27.60	\$55.20	\$82.80
Age 60 and over	\$4.52	\$9.02	\$22.54	\$45.08	\$90.16	\$135.24

\*Evidence of insurability may be required depending on the circumstances.

**C. Dependent Life Insurance (Select One Plan)**

Please  enroll\* my dependents in,  change\* my present plan to, or  terminate the plan checked below:

Qualified Dependent	<input type="checkbox"/> Plan A	<input type="checkbox"/> Plan B	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan D	<input type="checkbox"/> Plan E	<input type="checkbox"/> Plan F	<input type="checkbox"/> Plan G	<input type="checkbox"/> Plan H
Spouse**	\$10,000	\$5,000	\$5,000	\$10,000	---	\$20,000	\$20,000	---
Dependent Children to 6 months	\$2,500	\$1,500	---	---	\$2,500	\$2,500	---	\$2,500
Dependent Children 6 months-18 years***	\$5,000	\$3,000	---	---	\$5,000	\$10,000	---	\$10,000
<b>Monthly Contribution</b>	\$10.54	\$5.70	\$2.42	\$8.42	\$3.48	\$21.08	\$16.82	\$6.96

\*Evidence of insurability may be required depending on circumstances.

\*\*Spouse means a person to whom you are legally married.

\*\*\*18 and older if attending an educational institution and relying on the employee for financial support or incapacitated and proof received within 31 days of age limit.

**D. Waiver of Optional Life and Dependents Coverage**

I certify that I have been given the opportunity to enroll myself and my eligible dependents in the above coverage. I have declined the Optional and/or Dependents Life coverage and understand it will be necessary for me and my dependents to furnish evidence of insurability if I desire any of the above coverage in the future (other than during an open enrollment period or other exception detailed in the certificate booklet).



**E. Beneficiary Designation/Change**

Please complete all appropriate boxes in ink, printing legibly. If you do not designate one or more beneficiaries, policy proceeds will be paid as outlined in the Certificate of Coverage, unless otherwise regulated by law.

Basic Life and AD&D					
Primary Beneficiary Information (Allocation to all Primary Beneficiaries must equal 100%)					
Beneficiary Name	Address (Street, City, State, Zip)	Relationship	Date of birth	SSN	% of Benefit
Contingent Beneficiary Information (Allocation to all Contingent Beneficiaries must equal 100%)					
Beneficiary Name	Address (Street, City, State, Zip)	Relationship	Date of birth	SSN	% of Benefit
Optional Life and AD&D					
Primary Beneficiary Information (Allocation to all Primary Beneficiaries must equal 100%)					
Beneficiary Name	Address (Street, City, State, Zip)	Relationship	Date of birth	SSN	% of Benefit
Contingent Beneficiary Information (Allocation to all Contingent Beneficiaries must equal 100%)					
Beneficiary Name	Address (Street, City, State, Zip)	Relationship	Date of birth	SSN	% of Benefit

- If more room is needed to indicate additional primary or contingent beneficiaries, please attach a separate sheet and list the information indicated above for each beneficiary. Please sign and date all additional sheets as well as this original form.
- Your group life coverage is issued by Nationwide Life Insurance Company, One Nationwide Plaza, 4-06-101 Columbus, OH 43215. Please refer to the Certificate of Insurance and Insurance Contract for all plan details, including any exclusions, limitations and restrictions which may apply.

**F. Fraud Warning**

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**G. Employee Signature and Date (Required)**

I, the undersigned, certify that I have read the completed enrollment/change/termination form and agree that all answers in this form are true and complete to the best of my knowledge and belief. I hereby authorize my employer to deduct from my paycheck or earnings the amount required to cover my share of the coverage I have selected.

Employee Signature \_\_\_\_\_

Date \_\_\_\_\_

IC Signature \_\_\_\_\_

Date \_\_\_\_\_

Send *PERSONNEL CABINET COPY TO:*

Department of Employee Insurance  
Optional Insurance Branch  
501 High St, 2<sup>nd</sup> Floor  
Frankfort, KY 40601