Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Commonwealth of Kentucky
Employee Group Life Insurance Program
Enrollment/Change/Termination and Designation of Beneficiary Form
Group Insurance Contract: NP01002

2021 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 ☐ Male ☐ 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	☐Option 1 $5,000	☐ Option 2 $10,000	☐ Option 3 $25,000	☐ Option 4 $50,000	☐ Option 5 $100,000	☐ 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	☐Plan A	☐Plan B	☐Plan C	☐Plan D	☐Plan E	☐Plan F	☐Plan G	☐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 to age 26	$5,000	$3,000	---	---	$5,000	$10,000	---	$10,000
Monthly Contribution	$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.

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).

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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, 2nd Floor
Frankfort, KY 40601