Basic Term Life Insurance Enrollment Form
Voluntary Term Life Insurance – Employees, Spouse, Children

PLEASE CHECK ONE OF THE FOLLOWING

New Enrollment ☐ **Change Only** ☐ **Effective Date of enrollment**____________

This form may be used for Supplemental Life Insurance that is being offered to you. You may also us this form to enroll your spouse/child(ren) for life insurance, and/or necessary changes (i.e. beneficiary). **Evidence of Insurability will be required if you did not purchase additional life as a new hire and are now electing coverage for the first time**

SECTION I - EMPLOYEE INFORMATION

Name Last, First				**SSN**	**Date of Hire**
Date of Birth	**Age**	**Sex** (M or F)	**Employer**		
Employee Address Number and Street				**City, State, Zip**	

SECTION II - <u>BASIC LIFE & SUPPLEMENTAL</u> BENEFICIARY DESIGNATION

Primary Beneficiary

First, Middle Initial, Last Name	Date of Birth	Relationship / % of Proceed
Address	City, State, Zip Code	Social Security Number

First, Middle Initial, Last Name	Date of Birth	Relationship / % of Proceed
Address	City, State, Zip Code	Social Security Number

Contingent Beneficiary

First, Middle Initial, Last Name	Date of Birth	Relationship
Address	City, State, Zip Code	Social Security Number

I UNDERSTAND that the Beneficiary for any dependent coverage will be the insured Employee unless otherwise noted. As a covered Employee, you have the right to select a Beneficiary in accordance with the provisions of your policy. You may also have the right to change the beneficiary designation. If more than one Beneficiary is designated, payment will be made in equal shares to each of the designated Beneficiaries which survive the insured, unless some other allocation is specified by you in writing in accordance with the provisions of the policy. If no designated Beneficiary survives the insured, settlement will be made in accordance with the terms of the policy.

____________________________ ____________________

Signature **Date**

(please continue)

SECTION III – Supplemental Life/AD&D Selection

Employee Coverage:

Amount of Coverage : ____________ (Eligible for $10,000 to $300,000 addition coverage, in $10,000 Increments

Premium per Month: ____________ (See Rates on attached page)

For all other amounts enter coverage amount and premium here ________________/______________.

Employees must enroll in voluntary life to be eligible for spousal or child(ren) coverage

SECTION IV – Supplemental Spouse Life/AD&D Selection

Please make selection below: For rates, please refer to the attached page and enter premiums in the appropriate column. Premiums are based on spouse's age.

***Spouse Name*_______________________ *DOB*____________*SSN*_____________**

Spouse coverage, please circle election:

	$5,000	$10,000	$15,000	$20,000	$25,000
Premium Per Month					
Please Circle	Accept	Accept	Accept	Accept	Accept

SECTION V – Voluntary Child(ren) Life Selection

Dependent Child(ren) coverage, please circle election:

	$5,000	$10,000
Premium Per Month	$ .98	$ 1.96
Please Circle	Accept	Accept

Child(ren) premium amouts remain the same regardless of the number of children
Please list child(ren), SSN, Date of Birth on back or separate sheet.

SECTION VII - ELIGIBILITY AND AUTHORIZATION

I have read, understand and agree to the provisions printed and acknowledge that the information I have provided is accurate to the best of my knowledge. I AUTHORIZE the payroll deductions for the above specified coverage's and release other necessary information to the administrators of this program.

______________________________________ ______________________

Signature **Date**

SECTION VIII - WAIVE SUPPLEMENTAL COVERAGE

*My signature below certifies that I have been given the opportunity to participate in the Associated School Boards of South Dakota benefit program. The benefits have been clearly explained to me. After careful consideration I have decided not to participate in the benefits listed above. I understand that if I later decide to apply for coverage under this plan I may be required to furnish evidence of insurability.

______________________________________ ______________________

Employee Signature - I WAIVE coverage. **Date**

****Please return this completed form to the South Dakota School District Benefits Fund.***