University of Wisconsin System
Human Resources
780 Regent Street, Suite 305
Madison, WI 53715

MINNESOTA LIFE

Policy 32871-G

Individual and Family Group Term Life Insurance Application/Cancellation/Change Form Instructions

http://www.uwsa.edu/hr/benefits/ins/lindfam.htm

You have an open enrollment opportunity for life insurance coverage for yourself and family members through the Individual and Family Group Life Insurance Plan if you meet all four of the following criteria. If you do not enroll for all available coverage when you are first eligible, you may only apply for future coverage through Evidence of Insurability. Criteria for enrollment:

1. You are working for the University of Wisconsin System, and
2. Eligible for state contributions to the State of Wisconsin Group Health Insurance Program, and
3. Not collecting a Wisconsin Retirement System benefit, and
4. You apply within 30 days of your first eligibility date.

Enrolling Spouse and Children

- If you do not have a spouse or domestic partner at the time of your initial enrollment but later marry or enter a domestic partnership, you must apply within 30 days of the date that you have a spouse or domestic partner to insure.
- If you do not have a child at the time of your initial enrollment but later have a baby or adopt a child, you must apply within 30 days of the date of birth or date of adoption of your first child.

For an overview of the plan provisions, please review the brochure http://www.uwsa.edu/ins/lifbro.pdf or the certificate of insurance http://www.uwsa.edu/ins/lifcert.pdf for comprehensive program information.

EMPLOYEE INSTRUCTIONS:

The form has three Sections, one section for your personal information, one to indicate why you are submitting the form and one to indicate what coverage you are electing, reducing or canceling. Complete as follows:

1. Complete Section I - Employee Information.
2. Complete Section II - Enrollment or Change to indicate why you are filing the application, e.g. enrolling, canceling, reducing coverage, etc.
   a. Check Box A to indicate that you (the employee) are enrolling for coverage, then go to Section III.
   b. Check Box B to indicate that you are reducing life insurance coverage on yourself, your spouse/domestic partner or child, then go to Section III.
   c. Check Box C to indicate that you are canceling life insurance coverage on yourself, your spouse/domestic partner or child, then go to Section III.
   d. Check Box D to report a legal name change for you (the employee) then date, sign and submit the form.
3. Complete Section III - Employee Coverage.
   a. Indicate the level of coverage you want for yourself, your spouse and your children; or
   b. Indicate the level of coverage that you are reducing or canceling.
   NOTE: Coverage amounts for spouse/domestic partner or child cannot exceed the coverage you have on yourself.
   c. If canceling, check the plans you are electing to cancel.
   NOTE: Once employee coverage is canceled, all other life insurance coverage is automatically canceled.

Sign, date and submit the copy with your original signature to your campus payroll and benefits office.

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Human Resources
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Individual and Family Group Term Life Insurance Application/Cancellation/Change Request

Minnesota Life
400 Robert Street North
St. Paul, MN 55101-2098
Policy 32871-G

Section I: Employee Information Please Print

Name (last, first, middle initial)	Social Security number
Address (street, city, state, zip code)	
UW campus name	Date of birth (mo/day/yr)

Section II: Enrollment or Change Section. Check the appropriate boxes and complete corresponding box in Section III.

A. ☐ I elect to enroll for the life insurance coverage indicated below and meet the following eligibility requirements to enroll. Check all that apply:

- ☐ I am a new employee and meet all eligibility requirements explained on the instruction sheet of this form.
- ☐ I was previously enrolled in the plan and let coverage lapse while on layoff or leave of absence. I am re-enrolling within 30 days of returning to work. Spouse/Domestic Partner and child coverage is available ONLY if spouse/domestic partner and child were covered before layoff or leave of absence.

Date layoff/LOA began	Return to work date

- ☐ I was previously enrolled in the plan and have been rehired to an eligible position within 30 days since my previous appointment. REHIRED ANNUITANTS ARE INELIGIBLE.
- ☐ I elect to enroll my spouse or domestic partner. Check one of the following:
- ☐ I elect to enroll my spouse and am filing this application with my benefits coordinator within 30 days of the date of marriage. Date of marriage________________ .
- ☐ I elect to enroll my domestic partner and am filing this application with my benefits coordinator within 30 days of the date of filing my Affidavit for Domestic Partnership with my employer. Date of filing ____________ .
- ☐ I elect to add child coverage since I have a child to cover for the first time due to birth, adoption, marriage or filing an Affidavit of Domestic Partnership with my employer. I am filing this application with my benefits coordinator within 30 days of the earliest applicable event.

B. ☐ I elect to reduce life insurance coverage. I understand that spouse/domestic partner or child coverage amounts may not exceed my coverage amount.

C. ☐ I elect to cancel the life insurance coverage indicated below. Cancellation of my coverage will automatically cancel my spouse/domestic partner and child coverage.

D. ☐ I have legally changed my name to ________________________ .

Section III: Employee Coverage. Check ONLY the plans you are electing or canceling.

A. ☐ I elect the following coverage amount. **(Check ONLY one amount for employee, spouse/domestic partner and children.)**

Employee coverage ☐ $5,000 ☐ $10,000 ☐ $20,000 Spouse/Domestic Partner coverage ☐ $5,000 ☐ $10,000

Name of spouse/domestic partner	Spouse/domestic partner date of birth

Child(ren) coverage ☐ $2,500 ☐ $5,000 (Amount selected covers each child in the family)

Name of Child	Child Date of Birth	Name of Child	Child Date of Birth

B. ☐ Reduce the following coverage (check one or more as appropriate)

☐ Employee coverage to $________ ☐ Spouse/Domestic Partner coverage to $________ ☐ Child coverage to $________

C. Check all that apply:

☐ Cancel Employee coverage (cancels all coverage) ☐ Cancel Spouse/Domestic Partner coverage ☐ Cancel Child coverage

Notice: The certificate of insurance can be viewed online at http://www.uwsa.edu/hr/benefits/ins/lifcert.pdf or you can contact your benefits office for a printed copy. Retain a copy of the certificate for your records.

I agree to the provisions of the plan and hereby authorize the deduction of the monthly premium from my salary.

Date (mo/day/yr)	Employee signature
	X

Submit the completed enrollment to your Campus Payroll or Benefits Office.

For Office Use Only	**Affidavit of domestic partnership filed, if applicable** ☐ Yes ☐ No				**Group number 32871-G**
Date received by employer (mo/day/yr)	Received by	Hire date (mo/day/yr)	Coverage effective date (mo/day/yr)	Premium $	Processor initials