

- New Application
- Application Change
(to increase or decrease amount)

- Beneficiary Change



Yale University GROUP LIFE INSURANCE for FACULTY, MANAGERIAL & PROFESSIONAL EMPLOYEES

Name: _____
First
Middle Initial
Last

Soc. Sec. No. : _____ - _____ - _____ Birth date : _____ - _____ - _____

Hire date: _____ - _____ - _____ Department name: _____

Group **Non Contributory** Plan Basic Benefit: \$25,000

<u>Primary Beneficiary (ies):</u>	<u>Relationship</u>	<u>SSN:</u>	<u>DOB:</u>	<u>Address:</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

<u>Contingent Beneficiary (ies):</u>	<u>Relationship</u>	<u>SSN:</u>	<u>DOB:</u>	<u>Address:</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Group **Contributory** Plan

Amount of Insurance desired (check only one):

- 1 times salary 2 times salary 3 times salary 4 times salary 5 times salary \$50,000 only

<u>Primary Beneficiary (ies):</u>	<u>Relationship</u>	<u>SSN:</u>	<u>DOB:</u>	<u>Address:</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

<u>Contingent Beneficiary (ies):</u>	<u>Relationship</u>	<u>SSN:</u>	<u>DOB:</u>	<u>Address:</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Provisions of Group Life Insurance

*I accept the insurance provided by my Employer's Group Insurance Plan and authorize deductions from my earnings of the required contributions toward the cost of the insurance.

Please note all new hires must enroll within 60 days from date of hire or be subject to Medical Underwriting. If purchasing 3-5 times earnings the Medical History Statement is mandatory regardless of the 60 day enrollment period.

I understand that the insurance I do not choose to take at the present time may be obtained at a later date providing I complete a Medical History Statement approved by the insurance company.

* Unless otherwise provided, where two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the insured, or to the survivor or survivors. If no beneficiary survives, payment will be made in accordance with the terms of the policy.

This designation revokes any and all previous designations. The right to further change the beneficiary is reserved unto the insured.

Signature: _____ Today's date: _____

* I ACCEPT THE PROVISIONS STATED ABOVE

<p><i>This section to be completed by the Benefits Office</i></p> <p>Processed by: _____ Date: _____</p>
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