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

☐ Beneficiary Change

Yale University GROUP LIFE INSURANCE for CLERICAL & TECHNICAL, SERVICE & MAINTENANCE EMPLOYEES

Name:_____
First Middle Initial Last

Soc. Sec. No.: ___-___-___ Birth date:___-___-___ Hire Date:___-___-___

Group **Non Contributory** Plan

Basic Benefit: $5,000

Primary Beneficiary (ies):	Relationship	SSN:	DOB:	Address:

Contingent Beneficiary (ies):	Relationship	SSN:	DOB:	Address:

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

Primary Beneficiary (ies):	Relationship	SSN:	DOB:	Address:

Contingent Beneficiary (ies):	Relationship	SSN:	DOB:	Address:

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

This section to be completed by the Benefits Office
Processed by: *Date:*