

Life and AD&D and Disability Income Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee.

Name of Employer/Plan Sponsor University of Florida College of Medicine (Faculty)		Group/Plan Number 66284-4	Account Number/Location <input type="checkbox"/> 001 - Gainesville <input type="checkbox"/> 002 - Jacksonville
Class/Occupation	Date of Hire	Annual Salary	Employment Status: <input type="checkbox"/> Active Full-Time <input type="checkbox"/> Active Part-Time
This change is due to: (check all that apply) <input type="checkbox"/> Change in Coverage Amount <input type="checkbox"/> Other: _____ <input type="checkbox"/> Initial Eligibility Following Hire			Effective Date of Coverage or Change:

Employee Information

Employee Name (last, first, middle initial)	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth / /	Social Security #	UF I.D. #
Employee Local Address (street address, city, state, zip code)			Telephone Work () Home () Other ()	
Employee Permanent Address (street address, city, state, country, postal code)				

Disability Income Coverage

Monthly Income Benefits (LTD)	<input checked="" type="checkbox"/> Elect Coverage (Note: LTD coverage is employer provided.) <input type="checkbox"/> Elect Non-Taxable Benefit
-------------------------------	---

Employee Life Insurance

Basic Life	<input checked="" type="checkbox"/> Elect Coverage (Note: Basic Life insurance is employer provided.)
------------	---

Employee Accidental Death & Dismemberment Insurance

Basic AD&D	<input checked="" type="checkbox"/> Elect Coverage (Note: Basic AD&D insurance is employer provided.)
------------	---

Beneficiary Information Designate your beneficiary(ies) below.

Name of Beneficiary (last name, first, middle initial)	<input type="checkbox"/> Primary	Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Name of Beneficiary (last name, first, middle initial)	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Name of Beneficiary (last name, first, middle initial)	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Employee's Signature	Date Signed / /
----------------------	--------------------