UF | UNIVERSITY of FLORIDA

ING

ReliaStar Life Insurance Company
A member of the ING family of companies

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 ☐ 001 – Gainesville ☐ 002 – Jacksonville
Class/Occupation	Date of Hire	Annual Salary	Employment Status: ☐ Active Full-Time ☐ Active Part-Time
This change is due to: (check all that apply) ___Change in Coverage Amount ___Other: ____________ ___ Initial Eligibility Following Hire			Effective Date of Coverage or Change:

Employee Information

Employee Name *(last, first, middle initial)*	☐ Female ☐ 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)	☒ Elect Coverage *(Note: LTD coverage is employer provided.)* ☒ Elect Non-Taxable Benefit

Employee Life Insurance

Basic Life	☒ Elect Coverage *(Note: Basic Life insurance is employer provided.)*

Employee Accidental Death & Dismemberment Insurance

Basic AD&D	☒ 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)* ☐ Primary		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Name of Beneficiary *(last name, first, middle initial)* ☐ Primary ☐ Contingent		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Name of Beneficiary *(last name, first, middle initial)* ☐ Primary ☐ 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 / /