

**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 <b>University of Florida College of Medicine (Housestaff)</b>		Group/Plan Number <b>66285-2</b>	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"/> Initial Eligibility Following Hire <input type="checkbox"/> Other: _____			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.)
---

**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 / /
----------------------	--------------------