

LIFE INSURANCE / LEGAL PLAN ENROLLMENT FORM

P.O. Box 7424, Winston-Salem, NC 27109
Phone: 336-758-5996 Fax: 336-758-5004
Web Site: www.wfu.edu/hr

- New Employee Change of Status*
 Annual Enrollment Beneficiary Update

Payroll Effective Date MO BW

Coverage Date 07/01/06

1. Personal Information

Name (Last, First, Middle Initial)		Date of Birth
WFU ID	Department	Date of Hire

2. Basic Life / AD & D Enrollment (premiums paid by the University)

Your basic life coverage is _____ (rounded to the next higher \$1,000)

HR Use Only
500 GrpLife MO
503 GrpLife BW

3. Optional Life Plan Enrollment

Minimum coverage = \$10,000. Maximum coverage = \$500,000. Coverage that exceeds a total of three times annual salary requires evidence of insurability.

- Options
- 01 One times annual salary
02 Two times annual salary
03 Three times annual salary
04 Four times annual salary
05 Five times annual salary
- Cancel
 Waive

Formula to calculate life volume and cost:

Annual Salary \$ _____ x Option _____ = \$ _____ (Volume)

Volume \$ _____ ÷ \$1,000 x Rate For Age \$ _____ = Cost per Month

Age	Rates per \$1000	Age	Rates per \$1000	Age	Rates per \$1000
0 – 24	\$0.060	40 – 44	\$0.110	60 – 64	\$0.730
25 – 29	\$0.070	45 – 49	\$0.170	65 – 69	\$1.400
30 – 34	\$0.090	50 – 54	\$0.250	70 – 74	\$2.270
35 – 39	\$0.100	55 – 59	\$0.470	75 – 79	\$3.400

HR Use Only
345 OptLife MO
346 OptLife BW

4. Dependent Life Plan Enrollment

- | | | |
|---|--|---------------------------------|
| <input type="checkbox"/> Option 1 Spouse \$25,000 | <input type="checkbox"/> Option 3 Spouse Only \$25,000 | <input type="checkbox"/> Cancel |
| <input type="checkbox"/> Option 2 Spouse \$10,000 | <input type="checkbox"/> Option 4 Child(ren) Only \$10,000 | <input type="checkbox"/> Waive |
| <input type="checkbox"/> Option 2 Spouse \$10,000 | <input type="checkbox"/> Option 5 Spouse Only \$10,000 | |
| <input type="checkbox"/> Option 2 Child(ren) \$ 5,000 | <input type="checkbox"/> Option 6 Child(ren) Only \$ 5,000 | |

HR Use Only
355 DepLife MO
356 DepLife BW

5. Voluntary AD & D Enrollment

- Employee
 Employee & Family
 Cancel
 Waive

Monthly Cost
\$0.02 per \$1,000 of coverage
\$0.04 per \$1,000 of coverage

Note: Amount requested must be in increments of 10,000 not to exceed ten times your base annual salary.

Amount Requested: _____ Premium: _____

HR Use Only
290 VAD&D MO
291 VAD&D BW

6. Legal Plan Enrollment – ARAG

- Elect Cancel Waive

HR Use Only
360 Legal MO
361 Legal BW

7. Beneficiary Information

Primary Beneficiary Information: Designate your beneficiary(s) for basic life, optional life and voluntary AD&D below

Name, Address, Phone Number of Beneficiary

Social Security No. Relationship Date of Birth Benefit Percentage %

Name, Address, Phone Number of Beneficiary

Social Security No. Relationship Date of Birth Benefit Percentage %

Contingent Beneficiary Information: Designate your beneficiary(s) below

Name, Address, Phone Number of Beneficiary

Social Security No. Relationship Date of Birth Benefit Percentage %

Name, Address, Phone Number of Beneficiary

Social Security No. Relationship Date of Birth Benefit Percentage %

Signature of Employee: _____ Date: _____

HR Use Only

Application Approved by: _____ Date: _____ Entered by: _____ Date: _____