

**Fort Dearborn Group Insurance Election Form
Supplemental Life**



AURORA UNIVERSITY

Supplemental Coverage NOTE: Please mark the box or boxes for each coverage your are applying for. All coverage amounts are subject to the limitations and exclusions as stated in the policy

Type of coverage	authorizes my employer to payroll deduct		Amount of Coverage (in \$10,000 increments unless noted)
Employee Supplemental Life Evidence of insurability is required for coverage amounts over \$100,000	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Spouse/Partner Supplemental Life Rates are based on employee age Evidence of insurability required for coverage amounts over \$50,000	<input type="checkbox"/> Yes	<input type="checkbox"/> No	\$ _____
Child Supplemental Life Rate covers one or more children	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> \$5,000 (\$1.30/month) <input type="checkbox"/> \$10,000 (\$2.60/month)
Voluntary Accidental Death and Dismemberment* <input type="checkbox"/> Yes <input type="checkbox"/> No			Enter coverage amount below Cost for employee only is \$0.015 per \$1,000 of coverage <input type="checkbox"/> Employee Only \$ _____ <input type="checkbox"/> Family Plan cost is \$0.025 per \$1,000 of coverage Family amount \$ _____
*If electing VAD/D, you must elect Supplemental Life.			

Dependent information required if enrolling in dependent coverage:

Indicate name and expected date of graduation for those dependents who are full time students age 19 and over.

Name: _____ Expected Graduation date: _____

Name: _____ Expected Graduation date: _____

Dependents:

Name	Date of Birth	Relationship*	Status**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

* relationship: Sp=spouse, ch=child, sc= step child who lives with you, financially dependent

** status: S= full time student age 19-26 (if child); H= handicapped person; D= totally disabled person (may be subject to a delayed effective date, N= not applicable

Delayed effective date: Employee - initial insurance and any increased or additional insurance will be delayed if an employee is not in active employment because of an injury, sickness, leave of absence or temporary layoff on the date that insurance would otherwise be effective.

Dependents - Initial insurance coverage will be delayed if a dependent is totally disabled on the date that insurance would otherwise be effective. Exception: newborn children are insured from day 14.

Request for Signature: I understand that by signing and submitting this form to elect coverage, I am making a binding election for my benefits and am authorizing payroll deduction from my earnings. I understand that if I decline any of the coverages above, I cannot later change my mind during the plan year and elect these coverages, unless I experience a change in status.

Evidence of Insurability for life and disability plans will be required if any of the following is applicable:

- * you are a new hire and the coverage you are electing exceeds \$100,000 or electing more than \$50,000 for your spouse/partner
- * late entrant if you were previously eligible for coverage but declined to participate at that time.
- * you may only elect coverage as a Late Entrant during annual enrollment.

Employee Signature

Date

Spouse/Partner signature (required if electing coverage)

Date