Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT

Your Name (Last, First, Middle)			Group Name: **Tulane University**	Group Number(s): **647381**	Your Soc. Sec. No.
Your Address			City	State / ZIP	Date of Birth
☐ Male ☐ Female	Date of Hire/Rehire	Annual Earnings $	Hrs. Worked Per Wk.	Job Title/Occupation	

REASON FOR APPLICATION

Please indicate your reason for completing this application. Check all boxes that apply.

- ☐ New Hire Enrollment — **Date of change** ______________
- ☐ Beneficiary Change *Fill out Beneficiary section below*
- ☐ Name Change – Former Name ______________
- ☐ Add Employee Coverage
- ☐ Delete Employee Coverage
- ☐ Add Spouse/Same-Sex Domestic Partner
- ☐ Delete Spouse/Same-Sex Domestic Partner – Name ______________
- ☐ Add Child
- ☐ Delete Child
- ☐ Increase Coverage
- ☐ Decrease Coverage

LIFE

Please indicate your elections for Additional Life, AD&D, and Dependents Life insurance below

Basic Life Insurance

☒ Life Employer Paid *1.5 times your annual earnings to a maximum of $50,000*

Additional Life Insurance

☐ Additional Life Your requested amount $______________

You may elect .5, 1, 1.5, 2, 3, 4, or 5 times your annual earnings to a maximum of $1,000,000
Evidence of good health is required for amounts in excess of $500,000 or 3 times annual earnings

Additional AD&D Insurance

☐ Employee Only Your requested amount $______________

You may elect increments of $10,000 from $10,000 to a maximum of $500,000

☐ Employee and Dependents

Employee requested amount $______________ *You may elect increments of $10,000 from $10,000 to a maximum of $500,000*

Spouse/Same-Sex Domestic Partner Only -- *60 percent of your AD&D coverage amount*

Child(ren) Only -- *20 percent of your AD&D coverage amount for each child*

Spouse/Same-Sex Domestic Partner and Child(ren)

Spouse/Domestic Partner – 50 percent of your AD&D coverage amount
Child(ren) – 15 percent for each child

Dependents Life Insurance

☒ Dependents Life Spouse/Same-Sex Domestic Partner and Child(ren) Employer Paid

Flat $2,000 for your eligible Spouse/Domestic Partner and/or Child(ren)

☐ Spouse/Same-Sex Domestic Partner Life Requested amount $__________

You may elect increments of $10,000 from $10,000 to a maximum of $150,000
Evidence of good health is required for amounts in excess of $10,000

Spouse/Same-Sex Domestic Partner Name______________________________ Date of Birth__________

☐ Child(ren) Life Requested amount $__________

Flat $10,000 or $20,000 for your eligible child(ren)
Evidence of good health is required for amounts in excess of $10,000

> For same-sex domestic partner coverage, you must complete and attach a Same-Sex Domestic Partner Affidavit or have registered as same-sex domestic partners or members of a civil union with a government agency or office where such registration is available

BENEFICIARY

This designation applies to Life Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

SIGNATURE

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Employee Signature Required	Date (Mo/Day/Yr)

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:

  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.

- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated ____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.