GROUP LIFE INSURANCE ENROLLMENT/BENEFICIARY DESIGNATION

THE HARTFORD

EMPLOYER INFORMATION	**Employer Name:** Northern Michigan University	**Group Policy #** 888939

EMPLOYEE INFORMATION	**Name (First, MI, Last):**	**Date of Birth:**	**Employee SSN:**	
	Address:	**City:**	**State:**	**Zip:**
	Employee Class:	**Hours Per Week:**	**Date of Hire:**	

ENROLLMENT INFORMATION	☐ Initial Enrollment ☐ Annual Enrollment ☐ Family Status Change ☐ Other_____ ☐ Beneficiary Change Only	**Effective Date:**

BENEFITS AND ELECTIONS	**Basic Life and AD&D** (Univ Provided)	Equal to 1x salary rounded to the next thousand	
	Supplemental Employee Life and AD&D	☐ ½x Salary ☐ 1x Salary ☐ 2x Salary	☐ 3x Salary ☐ 4x Salary ☐ 5x Salary	☐ I decline enrollment ☐ Cancel my coverage
	Supplemental Dependent Life	☐ Option 1 $10,000 spouse/$5,000 child ☐ Option 2 $15,000 spouse/$10,000 child ☐ Option 3 $20,000 spouse/$10,000 child ☐ Option 4 $50,000 spouse/$10,000 child		☐ I decline enrollment ☐ Cancel my coverage

BENEFICIARY DESIGNATION

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you. A primary beneficiary is the beneficiary or beneficiaries that you name to receive the benefits if they are living at the time of your death. The primary beneficiaries are the first in line to receive death benefits. Contingent beneficiaries, or secondary beneficiaries, are those named to receive the insurance proceeds if no primary beneficiary is alive at the time you die.

Name	Social Security #	Date of Birth	Relationship	Percentage
Address		Phone #		☐ Primary ☐ Contingent
Name	Social Security #	Date of Birth	Relationship	Percentage
Address		Phone #		☐ Primary ☐ Contingent
Name	Social Security #	Date of Birth	Relationship	Percentage
Address		Phone #		☐ Primary ☐ Contingent
Name	Social Security #	Date of Birth	Relationship	Percentage
Address		Phone #		☐ Primary ☐ Contingent

OVER

EMPLOYEE CONFIR-MATION	I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer. I understand and agree that if I decline coverage now, but later decide to enroll, I may be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford. I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to my employer can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy. If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit(s) reduce at a specified age(s) stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration of benefits payable will be limited to a specified period which may start at a specified age and that a claim for benefits may not be approved for a pre-existing condition. I authorize payroll deductions from my wages to cover my cost of coverage when applicable. I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are required by The Hartford or by law and are not met, the policy will not be implemented and the coverage I have elected will not be in force.	
	Employee Signature:	**Date:**

C: Employee
Human Resources

NOTE: If you are an employee residing in AK, AZ, CA, ID, LA, NV, NM, TX, WA, WI or Puerto Rico, and you are naming someone other than your spouse as your beneficiary, you MUST complete the below Spousal Consent.

SPOUSAL CONSENT **For employees who reside in AK, AZ, CA, ID, LA, NV, NM, TX, WA, WI or Puerto Rico**	The beneficiary for insurance on the lives of your dependents will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions. A beneficiary for employee life or accidental death insurance may be changed upon written request. Consent For Community Property States Only: If you live in a community property state – **Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, and Wisconsin** – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. **Disclaimer:** Spousal consent does not apply to ERISA plans. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details. This will represent that, as spouse of the employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.	
	Spousal Consent Signature:	**Date:**