

STATE OF MISSISSIPPI
STATE AND SCHOOL EMPLOYEES' LIFE INSURANCE PLAN
ENROLLMENT/CHANGE REQUEST FORM
Underwritten by Aetna Life Insurance Company

PLEASE PRINT

AETNA POLICY # 876537

SECTION A: Employee/Employer Information

New Enrollment **Change**

Employee Last Name:	Employee First Name:	MI:	Social Security Number:	Birthdate (MMDDYYYY):	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Employee Home Address (number, street, city, state, zip code):				Employee Home Telephone Number ()	
Employer Name (name of Agency, School District, etc.):				Date of Employment:	
Employer Address (number, street, city, state, zip code):				Employer Telephone Number ()	

SECTION B: Waiver/Request To Cancel Coverage (Only Complete This Section To Waive Or Cancel Coverage)

Waiver of Coverage – I hereby decline to apply for life insurance coverage in the State and School Employees' Life Insurance Plan. I understand that an active employee who waives coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who declines to apply for continuation of coverage in the Plan within 31 days of the date his coverage ceases as an active employee, forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

Cancellation of Coverage – I hereby request that my life insurance coverage in the State and School Employees' Life Insurance Plan be cancelled. I understand that an active employee who cancels his coverage in the Plan may apply for coverage at a later date so long as he continues to qualify as an active employee. I further understand that late enrollee applicants are subject to medical evidence of insurability that may result in coverage being denied. I understand that a service retired employee or totally disabled employee who cancels his coverage in the Plan forfeits his right to participate in the State and School Employees' Life Insurance Plan and will not be allowed to apply at a later date.

SIGN HERE ONLY IF YOU DO NOT WANT LIFE INSURANCE COVERAGE!

_____ _____
Employee Signature **Date**

SECTION C: Type of Coverage (Check One)

ACTIVE EMPLOYEE: Life benefit amounts equal twice the amount of the employee's annual wage rounded to the next higher one thousand dollars. Minimum \$30,000; Maximum \$100,000.

- New Employee** – applying within 31 days of employment; coverage will become effective on the first day of employment.
- Late Enrollee Applicant** – applying after initial 31 days of employment; will be subject to medical evidence of insurability; coverage will become effective on the first day of the month after or coincident with date of approval by Aetna Life Insurance Company. **(Employee Must Also Complete and Attach AETNA EVIDENCE OF INSURABILITY STATEMENT form)**

Date of Employment: _____

RETIRED EMPLOYEE: Life benefit amounts limited to \$5,000, \$10,000, or \$20,000. Retired Employees are not eligible for AD&D coverage. A Retired Employee should apply prior to, but no later than 31 days after, the date Active Employee coverage terminates.

Date of Retirement: _____ **COVERAGE AMOUNT REQUESTED:** \$5,000 \$10,000 \$20,000

DISABLED EMPLOYEE: Life benefit amount is equal to employee's current benefit level at the time coverage ceases as an Active Employee. Disabled Employee must apply no later than 31 days from the date Active Employee coverage terminates. Aetna Life Insurance Company is solely responsible for evaluating applications for coverage continuation.

(Employee Must Also Complete and Attach AETNA GROUP DISABILITY and ATTENDING PHYSICIAN'S STATEMENT forms)

Date of Disability: _____

Employee Last Name	Employee First Name	MI	Social Security Number	Daytime Telephone # ()
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SECTION D: Beneficiary Information

Beneficiary Name and Address:				<input checked="" type="checkbox"/> Primary Beneficiary
Relationship:	Social Security Number:	Date of Birth:	Percentage:	
Beneficiary Name and Address:				<input type="checkbox"/> Primary Beneficiary <i>or</i> <input type="checkbox"/> Contingent Beneficiary *(PLEASE CHECK BENEFICIARY TYPE)
Relationship:	Social Security Number:	Date of Birth:	Percentage:	
Beneficiary Name and Address:				<input type="checkbox"/> Primary Beneficiary <i>or</i> <input type="checkbox"/> Contingent Beneficiary *(PLEASE CHECK BENEFICIARY TYPE)
Relationship:	Social Security Number:	Date of Birth:	Percentage:	
Beneficiary Name and Address:				<input type="checkbox"/> Primary Beneficiary <i>or</i> <input type="checkbox"/> Contingent Beneficiary *(PLEASE CHECK BENEFICIARY TYPE)
Relationship:	Social Security Number:	Date of Birth:	Percentage:	

* **Contingent Beneficiary(ies)** will only receive proceeds if **all** Primary Beneficiaries have predeceased the Insured.

If more than one **Primary Beneficiary** is named, the Primary Beneficiaries shall share equally unless otherwise indicated above. Likewise, if more than one **Contingent Beneficiary** is named, the Contingent Beneficiaries shall share equally unless otherwise indicated above. If you are naming more than one Contingent Beneficiary at 100% each, please indicate 1st contingent, 2nd contingent, 3rd contingent, etc., in the **Percentage:** block, and list each in the order of precedence.

SECTION E: Authorization and Certification

I apply for group term life insurance for myself through the State and School Employees' Life Insurance Plan (Plan). I understand that if my application is approved, coverage will become effective on the date fixed by the Plan or Aetna Life Insurance Company. I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the Aetna Group Policy #876537 and summarized in the Certificate of Coverage provided to me. I understand that any misrepresentation by me may result in the cancellation or rescission of coverage under the Plan. I understand that if I am a late enrollee applicant, any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent. I understand that my eligibility may be affected in the event I fail to sign this form within 31 days of the effective date of eligibility or that for any reason my employer does not receive notice of the Enrollment/Change Request within a reasonable time following the event. I understand and authorize that the appropriate premiums for the coverage requested will be deducted from my wages or retirement benefits, as appropriate, and authorize release of employment and payroll information or other such eligibility information to the Plan and/or Aetna Life Insurance Company as needed to verify my eligibility, benefit amounts, or other such information necessary in the proper administration of the Plan. Subject to the terms of Aetna Group Policy #876537, I request that any sum becoming payable by reason of my death be payable to the beneficiary(ies) listed above. It is my understanding that this designation shall operate so as to revoke all designations of beneficiary previously made by me under this Policy.

Employee Signature (Required)	Date
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FOR PERSONNEL/PAYROLL USE ONLY			
COVERAGE AMOUNT:	REQUESTED EFFECTIVE DATE:	DEPARTMENT CODE:	INFORMATION VERIFIED: (INITIAL AND DATE BELOW)