

## OSU Benefit Election /Change Form

*INSTRUCTIONS: This form is to be completed by the Employee. All new coverage or any increases in coverage will require evidence of insurability (proof of good health) if plan participation requirements are not met. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.*

Name of Employer/Plan Sponsor and Group Policy # OSU/A&M System                      627038 - 1	Employer Location	Effective Date of Coverage or Change:
This change is due to: _____ Initial Eligibility                      _____ Entrant		Change in Coverage _____ Amount

*\*A late entrant is an individual who is first enrolling for supplemental or dependent coverage after the first available opportunity.*

### Employee Information

Employee Name (last, first, middle initial)	<input type="checkbox"/> Female <input type="checkbox"/> Male	Date of Birth / /	Continuous Reg Empl Date	Employee ID #
Employee Address (street address, city, state, zip code)			Telephone Work (    ) Home (    )	

### Basic Employee Life Insurance

Basic Life/AD&D	<input type="checkbox"/> Employee Only— Basic Life Insurance and AD&D is OS&A&M System-provided (two times annual salary not to exceed \$200,000)
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### Employee Supplemental Life Insurance

**Employee Supplemental Life – Maximum Limit = two times annual salary up to \$250,000, whichever is less, when initially eligible.** When you are first eligible for supplemental life coverage, you can elect up to the Max limit without evidence of insurability. At each annual enrollment, you can elect to increase supplemental life coverage by \$5,000 (total coverage not to exceed the Max Limit) without evidence of insurability. Total supplemental life coverage up to five times basic annual earnings not to exceed \$750,000 is available if you complete an Evidence of Insurability form and ReliaStar Life approves it.

Supplemental Life Election	<input type="checkbox"/> I currently am enrolling in or have supplemental life coverage of: \$ _____ (\$5,000 increments). <input type="checkbox"/> I am applying for additional supplemental life coverage of:     \$ _____ (\$5,000 increments). <input type="checkbox"/> Total supplemental life coverage (current plus additional):     \$ _____ (\$5,000 increments). <hr style="border-top: 1px dashed black;"/> <input type="checkbox"/> Waive/Cancel Employee Supplemental Life Coverage                      Max=\$ _____
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### Spouse Life Insurance Coverage

**Spouse Life Insurance - Option to elect up to one times employee annual salary or \$125,000 whichever is less without evidence of insurability, when initially eligible.** When you are initially eligible for spouse coverage, you can elect coverage in \$5,000 increments without evidence of insurability up to one times your annual earnings not to exceed \$125,000. At each annual enrollment, you can elect to increase spouse supplemental life coverage by \$5,000 not to exceed Maximum Limit. At all other times, an Evidence of Insurability form must be completed, and it will not be in effect until approved by ReliaStar. Coverage is available up to \$375,000, with approved evidence of insurability. Spouse coverage cannot exceed 50% of the employee combined Basic and Supplemental amounts.

Spouse Life Election (Spouse Not OSU Employee)	<input type="checkbox"/> I currently am enrolling in or have spouse supplemental life of: \$ _____ (\$5,000 increments). <input type="checkbox"/> I am applying for additional spouse supplemental life of:     \$ _____ (\$5,000 increments). <input type="checkbox"/> Total Supplemental Life Coverage (current plus additional):     \$ _____ (\$5,000 increments). Spouse Name: _____ SSN _____ Date of Birth ____/____/____ <hr style="border-top: 1px dashed black;"/> <input type="checkbox"/> Waive/Cancel Spouse Life Coverage                      Max=\$ _____
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### Child (ren) Life Insurance Coverage

**Child(ren) Life Insurance – Option to elect one of four coverage amounts.** When you are initially eligible for dependent child(ren) coverage, you can elect coverage without evidence of insurability. At all other times, you must complete an Evidence of Insurability form for your child (ren) and it will not be in effect until ReliaStar has approved it. Dependent coverage is limited to 50% of the employee's coverage amount.

Child(ren) Life Election	<input type="checkbox"/> \$ 2,500 for each eligible dependent child. <input type="checkbox"/> \$ 5,000 for each eligible dependent child. <input type="checkbox"/> \$ 7,500 for each eligible dependent child. <input type="checkbox"/> \$10,000 for each eligible dependent child. <hr style="border-top: 1px dashed black;"/> <input type="checkbox"/> Waive/Cancel Child(ren) Life Coverage	<ul style="list-style-type: none"> <li>• Children can be covered from birth to age 21. Older children are eligible if full-time students.</li> <li>• Children under six months of age are covered at the following schedule.              Birth to 14 days = \$100                      14 days to 6 months = \$1,000</li> </ul>
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**Contact your Human Resources Office for additional information about the higher coverage limits or general life information.**

## Beneficiary Information for Employee Life Coverage

(Beneficiary for Employee Basic and Supplemental must be the same.)

*Life proceeds will be split equally among beneficiaries unless otherwise designated.*

**Note: The employee is the beneficiary for spouse or children insurance coverage, if applicable.**

Primary Beneficiary (last name, first, middle initial)	Address	Relationship	Benefit % (MUST total 100%)*
Contingent Beneficiary (last name, first, middle initial)	Address	Relationship	Benefit % (MUST total 100%)*

### American Fidelity Plans allow 90 days from hire to enroll.

Long Term Disability – Long Term Disability coverage is employee paid. Proof of Insurability is required if enrolling or increasing coverage level after thirty days from initial benefits eligibility.				
Long Term Disability Election	50% <input type="checkbox"/>	60% <input type="checkbox"/>	70% <input type="checkbox"/>	Waive/Cancel <input type="checkbox"/>

Flexible Benefits – The maximum contribution for the uninsured medical account and the dependent care account is \$5,000 each per calendar year. Health, Dental and Vision premiums paid by the employee will be tax-sheltered, unless otherwise designated. If you do NOT wish for your premiums to be sheltered, please note here: _____				
Employee Contribution to Uninsured Medical	\$ _____ Amt. Pay period	# pay periods	\$ _____ Goal thru 12/31	Waive/Cancel <input type="checkbox"/>
Employee Contribution to Dependent Care	\$ _____ Amt. Pay period	# pay periods	\$ _____ Goal thru 12/31	Waive/Cancel <input type="checkbox"/>

### READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- ❖ I authorize my employer to deduct from my pay the premium, if any, for the elected coverage.
- ❖ I recognize that any change in my Flexible Benefits must be necessitated by, and consistent with IRS Section 125 regulations. These changes must be made within 30 days of the qualifying event and within the current plan year. I must be able to produce documentation that authenticates the qualifying event upon request.
- ❖ To the best of my knowledge and belief, the information I have provided on this form is correct.
- ❖ I understand that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.
- ❖ I understand that coverage will begin the first of the month following my eligibility.
- ❖ I understand my coverage begins the first of the month following the completion and return of this form if a change is requested mid-year. If evidence of insurability is required, coverage will begin the first of the month following approval by a ReliaStar Insurance Underwriter.

Employee's Campus Phone:	Home Phone:
Employee's Signature:	Date Signed:

OSU/A&M Office Use Only	Employee's Annualized Salary \$ _____	EOI Required Employee \$ _____  Spouse \$ _____	Eligibility for Coverage Confirmed By: Date:	Coded  By: Date:
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