Section 4: Forms

In this section you will find forms that were previously mentioned.

If you do not know an effective date, plan numbers, codes, etc., leave them blank as we will assist with these entries.

The following forms **REQUIRE** your completion:

1. Basic Life Insurance Beneficiary Designation Application
2. LTD Exempt Enrollment Form
3. Designation of Beneficiary
    - Do not sign this form until you meet with us, as we will need to notarize this form.
4. PayFlex Flexible Spending Accounts Enrollment Form
5. Dependent Information Sheet

The following **OPTIONAL** forms are completed only if the benefit is selected:

1. Optional Accidental Death Enrollment Application
2. Optional Group Term Life Insurance Enrollment

RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

BASIC LIFE INSURANCE BENEFICIARY DESIGNATION APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
19th Floor, 312 Rosa L. Parks Avenue • Nashville, Tennessee 37243 • 615.741.3590 or 800.253.9981

TYPE OF REQUEST

- [x] New Enrollment
- [ ] Beneficiary Add/Change

Effective date of beneficiary designation: _____

Enrolled in health coverage:
- [ ] Yes
- [ ] No

If yes, type of health coverage:
- [ ] Employee only
- [ ] Employee + dependents

This application is to be used to designate a beneficiary for basic life insurance coverages. Individuals who elect **NOT** to enroll in health insurance will be provided with basic term life and basic accident coverage with the premium being provided by the State of Tennessee. These amounts of coverage **CANNOT** be increased.

Individuals who **DO** elect health coverage will also receive the same state support; however, the amount of coverage will increase as your salary increases, with additional premiums deducted from your paycheck. If enrolling in health coverage, covered dependents will also receive life insurance benefits; however, the amount of coverage is different from that of an employee.

Please refer to the eligibility and enrollment guide for further information.

EMPLOYEE INFORMATION

Name	Social Security Number	Edison ID (if known)	
Employing Department/Agency Tennessee Tech University	Dept ID 9001700000	Date of Hire	Date of Birth
Work Address	City	State	Zip Code
Home Address	City	State	Zip Code
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Gender ☐ Male ☐ Female	Daytime Phone Number	

AUTHORIZATION

I understand that this enrollment is NOT for health insurance coverage and is for basic term life and basic accident coverage only. Unless I enroll in family health insurance, coverage is provided to the employee only (not spouse or child). If I enroll in family health insurance coverage, my covered dependents will also be enrolled in basic life coverage; however dependents do not elect a beneficiary as the benefit will automatically default to me as the employee. I further understand that a new application must be completed and returned to my agency benefits coordinator any time I want to designate a new beneficiary. Failure to designate a beneficiary will result in the proceeds being paid to my spouse, children, parents or estate according to applicable contract provisions in the event of my death.

I authorize the state group insurance program to release information to their life insurance contractor on behalf of myself and all family members (name, address, social security number, age, gender, salary, enrollment effective/termination date) required to establish eligibility and coverage levels for the purpose of obtaining life insurance coverage. This authorization shall be in force for the time period I have a pending application or am enrolled with this life insurance company. The state group insurance program will not condition treatment, payment or enrollment eligibility on the signature of this authorization and may not have the right to control further disclosures of this information.

Upon termination of employment, I may convert my basic term life coverage to an individual policy with the insurance company. Payment of monthly premiums directly to the insurance company will be my responsibility.

I confirm that all information that I have provided on this application is accurate. I understand that providing false and/or misleading information may subject me to disciplinary and/or legal action. I authorize my employer to deduct the required premium from my salary/wages.

_____ _____

Employee Signature Date

Complete beneficiary designation on back of this application and return to your agency benefits coordinator

Name	Edison ID	OR	SSN

PRIMARY BENEFICIARY DESIGNATION

Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Total for Primary Beneficiary (must be 100%)			**Total**

CONTINGENT BENEFICIARY DESIGNATION

Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Total for Contingent Beneficiary (must be 100%)			**Total**

NOTE: Contingent beneficiary will only receive benefits if all primary beneficiaries are deceased.

The Lincoln National Life Insurance Company
P.O. Box 2616, Omaha, NE 68103-2616
Phone: (800) 423-2765 Fax: (877) 573-6177

ENROLLMENT FORM FOR GROUP INSURANCE

Please Use Ink or Type	GROUP ID: **TENNBOR**	GROUP POLICY #: **1023334000000**	Billing Division or Location:

A. Employee Information (Complete for ALL Enrollments)

Employer Name/Company Name (Please Print)			County	Employer ZIP	State
Employee Last Name	First Name	Middle Initial	Social Security Number		Date of Birth
Street Address			City	State	Zip
Gender: ☐ Male ☐ Female	Marital Status: ☐ Married ☐ Single		Home Phone ( )		Work Phone ( )

Completed By Employer

Average Hours Worked Per Week:	Occupation:	
Earnings: ☐Hourly ☐Monthly ☐Weekly ☐Yearly $_____	Date of Full-Time Employment:	Rehire Date:

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

TYPE OF COVERAGE	AMOUNT OF COVERAGE	TOTAL PREMIUM
Voluntary Long Term Disability ☐**Yes** ☐**No***	☐ **Level 1 Plan – 50% to $2,000 max** ☐ **Level 2 Plan – 60% to $4,000 max** ☐ **Level 3 Plan – 60% to $7,000 max**	$

*By selecting No, application for coverage at a later date may require further medical information and/or a physical exam, which will be at my own expense.

--Actual deductions may vary slightly from above illustrations due to rounding--

E. Request for Coverages

This coverage has been offered to me and after careful consideration of the benefits, I have decided to:

- ☐ **REQUEST COVERAGE for which I am or may become eligible under the group policies issued by The Lincoln National Life Insurance Company.** I hereby enroll for group insurance, for which I am eligible or may become eligible. If contributions are required, I authorize my employer to deduct premiums from my salary.
- ☐ **NOT ENROLL myself in the Program.** I understand that if I enroll for coverage at a later date, and if a physical examination or further medical information is required, it will be at my own expense.

NOTE: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS.

The insurance requested on this enrollment form will not be effective until approved by the Group Insurance Service Office of The Lincoln National Life Insurance Company, or its insurance partners, and the initial premium is paid to The Lincoln National Life Insurance Company. A delayed effective date will apply if the employee is not Actively at Work or an Active Member, or a dependent is in a period of limited activity on the date insurance would otherwise take effect.

Employee Full Name:_____ Employee Signature:_____ Date:_____

TENNESSEE TECHNOLOGICAL UNIVERSITY
DESIGNATION OF BENEFICIARY

Employee Name _____ T#: _____

In accordance with the TTU procedure to disburse final compensation of wages and benefits in the event of employee death, I hereby designate the beneficiary(ies) listed below:

Complete Sections I and III or Sections II and III

Section I

☐ I designate payment of all wages and benefits to the same beneficiary(ies) designated for retirement benefits.

Beneficiary Name: _____

Section II

Wages: (TCA 830-2-103)

Last Name	First Name	Middle	Soc. Sec. No.	Date of Birth	Sex	Relationship

Annual Leave (TCA 88-50-808, Section III.E.)

Last Name	First Name	Middle	Soc. Sec. No.	Date of Birth	Sex	Relationship

Sick Leave (TCA 88-50-808, Section VII)

Last Name	First Name	Middle	Soc. Sec. No.	Date of Birth	Sex	Relationship

Compensation Time (TCA 88-50-808)

Last Name	First Name	Middle	Soc. Sec. No.	Date of Birth	Sex	Relationship

Estate Address: _____

Section III

I, the employee, revoke any previous beneficiary nominations and direct that the forgoing designations supersede any previously filed.

Employee Signature:		Date:	

STATE OF TENNESSEE COUNTY OF PUTNAM

_____ personally appeared before me this the _____ day of _____, _____, who makes oath that (they) executed the foregoing instrument.

(NOTARY SEAL)

Notary Public _____

My Commission Expires: _____

Health/Limited/Dependent Care Flexible Spending Account (FSA) Enrollment Form

EMPLOYER MUST FILL-IN
Re-enrollment __ New __ Change __
Effective Date _____
1st Deduction Date _____
Payroll Mode W B S M Q
Division Code _____

I. Personal Information (Please print clearly and provide complete and accurate information.)

Your Employer: _____ **Employer ID#** _____

Member # _____ **Your Name** _____
(This may be your SSN or employer assigned number) (Last) (First) (MI)

Address _____ **City** _____ **State** _____ **Zip** _____-_____

☐ *Check if this address is new within last year.* **Date of Birth** ____/____/____ **Hire Date** ____/____/____

II. Election Information (Please check the appropriate box to indicate if you wish to enroll, or do not wish to enroll, and sign below.)

☐ Yes, I wish to participate in the **Limited Purpose and/or Dependent Care FSA** plan and authorize payroll reduction from my salary on a pre-tax basis in the amount(s) indicated below, and continuing until this election is amended or terminated or until the Plan Year ends. Employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

☐ Yes, I wish to participate in the **Heath Care and/or Dependent Care FSA** plan and authorize payroll reduction from my salary on a pre-tax basis in the amount(s) indicated below, and continuing until this election is amended or terminated or until the Plan Year ends. Employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

☐ I have been offered the opportunity to enroll in the flexible spending account plan and do not wish to enroll at this time. However, my employer-sponsored benefit coverage contributions are automatically reduced from my compensation on a pre-tax basis.

BENEFIT CHOICES	PER PAY PERIOD AMOUNT		NUMBER OF PAY PERIODS		PLAN YEAR AMOUNT
Health Care Flexible Spending Account (FSA) • If you are enrolled in a Health Savings Account, you cannot enroll in a Health Care FSA.	$_____.____	X	_____	=	$_____.____
Limited Purpose Flexible Spending Account • Only available if you are enrolled in a Health Saving Account.	$_____.____	X	_____	=	$_____.____
Dependent Day Care Flexible Spending Account • If married, this amount is less than my spouse's earned income. Please refer to the IRS guidelines for further information.	$_____.____	X	_____	=	$_____.____

I understand that:

- If enrolled in an HSA, I may only participate in a Limited Purpose FSA.
- This election can only be changed or revoked during the Plan Year if I have a change in status as defined in the Plan or if I am no longer eligible to participate. The new election must be consistent with my change in status, must be applied for within 30 days of the change, and is subject to final approval by my employer.
- This election will be automatically changed or cancelled, if necessary, to comply with provisions of the Internal Revenue Code or if required employer-sponsored benefit contributions increase or decrease.
- The maximum exclusion under a Dependent Care Reimbursement Account for married individuals filing a joint return is $5,000 per calendar year. Married individuals filing separately will get a lower exclusion ($2,500 per calendar year). IRS Form 2441 must be filed with my personal income tax return.
- Any amounts remaining in my reimbursement accounts at the end of the Plan Year will be forfeited.
- Salary contributed into one reimbursement account cannot be transferred and used for expenses in any other account.
- A new Enrollment Form must be completed each Plan Year. If I do not complete and return an Enrollment Form during Open Enrollment, I forfeit the opportunity to participate in the Benefit Choices outlined above.
- Social Security and Medicare taxes are not being withheld on the amount of my salary reduction under this election.
- The amount of salary reductions may not be claimed on my or my spouse's income tax returns.
- If my employment terminates, only medical expenses incurred through my period of coverage as defined in the Plan can be considered for reimbursement.
- I understand all claims submitted for reimbursement are subject to substantiation requirements and I am required to, and agree to, provide documentation as requested.
- If using the PayFlex Debit Card, I agree to use the card for eligible expenses only and retain all itemized receipts/statements. I agree to read and adhere to the cardholder statement I receive with the card and I understand the card is subject to inactivation if I do not comply with the provisions or upon termination of employment.
- Any expenses I pay for with the PayFlex Debit Card or for which I claim reimbursement will not have been nor will I seek to have reimbursed elsewhere.

III. Pre-Authorization for Direct Deposit (If you are already enrolled in direct deposit or do not wish to, ignore this section.)

☐ I authorize PayFlex Systems USA, Inc. to initiate a credit and/or debit entry to my account for my PayFlex reimbursements.
This agreement is to remain in full effect until written notification is supplied by me to PayFlex terminating this agreement.
A "VOIDED" CHECK MUST ACCOMPANY DIRECT DEPOSIT APPLICATION

✍ ***Employee Signature*** _____ ***Date*** _____ ***Rev.11/2014***

Dependent Information Sheet

Employee T#		Effective date of coverage:	
First Name	MI	Last Name	
Date of Birth			
Gender	○ M	○ F	
Marital Status	○ S ○ M	○ D	○ W
Social Security Number			
Home Address	City	ST	ZIP
County			

DEPENDENT INFORMATION			
First Name	MI	Last Name	
Date of Birth	Social Security Number		
Relationship	Gender	○ M	○ F
Acquire date *	Has this dependent ever employed/student of TTU?		
Covered: ○ Medical	○ Dental	○Vision	
First Name	MI	Last Name	
Date of Birth	Social Security Number		
Relationship	Gender	○ M	○ F
Acquire date *	Has this dependent ever employed/student of TTU?		
Covered: ○ Medical	○ Dental	○Vision	
First Name	MI	Last Name	
Date of Birth	Social Security Number		
Relationship	Gender	○ M	○ F
Acquire date *	Has this dependent ever employed/student of TTU?		
Covered: ○ Medical	○ Dental	○Vision	
First Name	MI	Last Name	
Date of Birth	Social Security Number		
Relationship	Gender	○ M	○ F
Acquire date *	Has this dependent ever employed/student of TTU?		
Covered: ○ Medical	○ Dental	○Vision	
First Name	MI	Last Name	
Date of Birth	Social Security Number		
Relationship	Gender	○ M	○ F
Acquire date *	Has this dependent ever employed/student of TTU?		
Covered: ○ Medical	○ Dental	○Vision	

* The acquire date is the date of marriage, birth, adoption or guardianship.

Employee Signature	Date

Definitions and Required Documents

Spouse: A person to whom the participant is legally married

** You will need to provide a document proving marital relationship **AND** a document proving joint ownership.

Proof of Marital Relationship

- Government issued marriage certificate or license
- Naturalization papers indicating marital status

Proof of Joint Ownership

- Bank Statement issued within the last six months with both names; **or**
- Mortgage Statement issued within the last six months with both names; **or**
- Residential Lease Agreement within the current terms with both names; **or**
- Credit Card Statement issued within the last six months with both names; **or**
- Property Tax Statement issued within the last 12 months with both names; **or**
- The first page of most recent Federal Tax Return filed showing "married filing jointly" (if married filing separately, submit page 1 of both returns) or form 8879 (electronic filing)

***** If just married in the current calendar year, a marriage certificate only is acceptable proof of eligibility***

Natural (biological) child under age 26: A natural (biological) child

- The child's birth certificate; **or**
- Certificate of Report of Birth (DS-1350); **or**
- Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240); **or**
- Certification of Birth Abroad (FS-545)

Adopted child under age 26: A child the participant has adopted or is in the process of legally adopting

- Court documents signed by a judge showing that the participant has adopted the child; **or**
- International adoption papers from country of adoption; **or**
- Papers from the adoption agency showing intent to adopt

Child for whom the participant is legal guardian: A child for whom the participant is the legal guardian

- Any legal document that establishes guardianship

Stepchild under age 26: A stepchild

- Verification of marriage between employee and spouse (as outlined above) and birth certificate of the child showing the relationship to the spouse; **or**
- Any legal document that establishes relationship between the stepchild and the spouse or the member

Child for whom the plan has received a qualified medical child support order: A child who is named as an alternate recipient with respect to the participant under a qualified medical child support order (QMCSO)

- Court documents signed by a judge; **or**
- Medical support orders issued by a state agency

Disabled dependent: A dependent of any age (who falls under one of the categories previously listed) and due to a mental or physical disability, is unable to earn a living. The dependent's disability must have begun before age 26 and while covered under a state sponsored plan.

- Documentation will be provided by the insurance carrier at the time incapacitation is determined

RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

OPTIONAL ACCIDENTAL DEATH ENROLLMENT APPLICATION

State of Tennessee • Department of Finance and Administration • Benefits Administration
19th Floor, 312 Rosa L. Parks Avenue • Nashville, Tennessee 37243 • 615.741.3590 or 800.253.9981

TYPE OF REQUEST	ACTION FOR ENROLLMENT CHANGE
☑ New Enrollment ☐ Employee only ☐ Employee + dependents ☐ Enrollment Change	☐ Add Dependent ☐ Terminate Dependent ☐ Update Dependent Eligibility ☐ Terminate Coverage ☐ Add/Change Beneficiary ☐ Change Coverage Type to: ☐ Single ☐ Family Effective Date of Change: _____

EMPLOYEE INFORMATION

First Name	MI	Last Name	Date of Birth	Gender	Marital Status
				☐ M ☐ F	☐ S ☐ M ☐ D ☐ W

Social Security Number	Employing Agency	Daytime Phone Number	Edison ID

Home Address	City	ST	ZIP Code

DEPENDENT INFORMATION

Name (First, MI, Last)	Date of Birth	Relationship	Gender	Acquire date *	Social Security Number
			☐ M ☐ F		
			☐ M ☐ F		
			☐ M ☐ F		
			☐ M ☐ F		

* **The acquire date is the date of marriage, birth, adoption or guardianship.**
Proof of a dependent's eligibility must be submitted with this application for all new dependents.

AUTHORIZATION

I confirm that all the above information is accurate. I understand that providing false and/or misleading information may subject me to disciplinary and/or legal action. I authorize my employer to deduct the required premium from my salary/wages.

I authorize the state group insurance program to release information to their life insurance contractor on behalf of myself and all family members (name, address, social security number, age, gender, salary, enrollment effective/termination date) required to establish eligibility and coverage levels for the purpose of obtaining life insurance coverage. This authorization shall be in force for the time period I have a pending application or am enrolled with this life insurance company. The state group insurance program will not condition treatment, payment or enrollment eligibility on the signature of this authorization and may not have the right to control further disclosures of this information.

I understand that a new application must be completed and returned to my agency benefits coordinator any time I want to designate a new beneficiary. Failure to designate a beneficiary will result in the proceeds being paid to my spouse, children, parents or estate according to applicable contract provisions in the event of my death. Dependents do not elect a beneficiary as the benefit will automatically default to me as the employee.

_____ _____

Employee Signature Date

Complete beneficiary designation on back of this application and return to your agency benefits coordinator

Name	Edison ID	OR	SSN

PRIMARY BENEFICIARY DESIGNATION

Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Total for Primary Beneficiary (must be 100%)			**Total**

CONTINGENT BENEFICIARY DESIGNATION

Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Name	Social Security Number	Relationship	Percent of Benefit
Home Address	City	State	Zip Code
Total for Contingent Beneficiary (must be 100%)			**Total**

NOTE: Contingent beneficiary will only receive benefits if all primary beneficiaries are deceased.

Optional Group Term Life Insurance Enrollment

Minnesota Life Insurance Company - A Securian Company
Group Administration Department • 400 Robert Street North • St. Paul, Minnesota 55101-2098

MINNESOTA LIFE

EMPLOYER NAME: State of Tennessee **POLICY NUMBER: 34175**

Reason for Enrollment: ☑ New Hire ☐ Family Status Change Date of Family Status Change _____ ☐ Annual Enrollment

1. Complete sections A, B, and F.
2. If you are electing coverage on your dependents, complete sections C, D, and/or E.

If you have questions, please contact Minnesota Life at 1-866-881-0631.

A. EMPLOYEE INFORMATION

First name | Middle initial | Last name

Email address

Street address	City	State	Zip code

Date of birth	Social Security number	Date of employment	Gender
			☐ Male ☐ Female

Total amount of insurance requested ($5,000 increments to a maximum of 7 times base annual salary or $500,000, whichever is less. Up to 5 times base annual salary is guaranteed if elected within 30 days of hire. Electing 6x or 7x base salary will require you to complete the separate Evidence of Insurability form.)

$ ☐ Check this box for the $5,000 Annual Enrollment increase ONLY

B. EMPLOYEE BENEFICIARY INFORMATION

Primary beneficiary(ies) designation (include full name and address) *The person or persons named will receive the benefits.*	Relationship	Share % (Primary beneficiaries must total 100%)

Contingent beneficiary(ies) designation (include full name and address) *If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s).*	Relationship	Share % (Contingent beneficiaries must total 100%)

PLEASE NOTE: If you do not designate a beneficiary, any death proceeds would be paid out at State of TN's plan default:
1. Spouse 2. Child(ren) 3. Parent(s) 4. Estate of Insured

C. SPOUSE INFORMATION

First name | Middle initial | Last name

Email address

Has your spouse been hospitalized, advised to seek medical treatment, or received disability benefits in the past six months? ☐ Yes ☐ No

Date of birth	Social Security number	Gender
		☐ Male ☐ Female

Total amount of Spouse Optional Term Life insurance requested

☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 (Spouse under age 55 only)
☐ $25,000 (Spouse under age 55 only) ☐ $30,000 (Spouse under age 55 only)

D. SPOUSE BENEFICIARY DESIGNATION (if no beneficiary is designated, employee will be the default beneficiary for spouse coverage)

Primary beneficiary(ies) designation (include full name and address) *The person or persons named will receive the benefits.*	Relationship	Share % (Primary beneficiaries must total 100%)

Contingent beneficiary(ies) designation (include full name and address) *If the primary beneficiary(ies) is no longer living, the benefit is paid to this person(s).*	Relationship	Share % (Contingent beneficiaries must total 100%)

E. CHILDREN INFORMATION (Employee is the beneficiary of child coverage)

List of names and dates of birth for your eligible children:

Total amount of insurance requested

☐ $5,000 ☐ $10,000

F. AUTHORIZATION

I authorize my employer to withdraw premiums from my salary to pay for supplemental insurance coverage.

I authorize the State Group Insurance Plan to release to Minnesota Life on behalf of myself and all family members information (name, address, Social Security number, age, gender, salary, enrollment effective/termination dates) required to establish eligibility and coverage levels for the purpose of obtaining life insurance coverage. This authorization shall be in force for the time period I have a pending application or am enrolled with this life insurance company. The State Group Insurance Plan will not condition treatment, payment, or enrollment eligibility on the signature of this authorization and may not have the right to control further disclosures of this information.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Employee signature	Daytime telephone number	Evening telephone number	Date signed
X			