Galena Park ISD

Group Life Insurance products provided by United HealthCare Insurance Company.

A. EMPLOYEE INFORMATION

☐ Enroll ☐ Cancel ☐ Address Change ☐ Name Change ☐ Other Gender ☐ M ☐ F Date

Last Name	First Name	M.I.	Social Security Number	Date Of Birth	Date of Hire

Street Address	Apt No.	City	State	Zip Code	County

Home Phone	Work Phone	Job Title	Salary	
				☐ Single ☐ Married

B. PRODUCT SECTION - Application for (check all that apply):

☒ **$25,0000 Basic Life and AD&D Life Insurance (automatic)**

Employee Supplemental Life and AD&D Insurance

☐ **Supplemental Employee Life and AD&D $_____ benefit amount ($10,000 increments up to $300,000, not to exceed 2 times salary)**
☐ **Waive Coverage**

Spouse Supplemental Life Insurance

☐ **Supplemental Spouse Life $_____ benefit amount ($10,000 increments up to $50,000 not to exceed 50% of the employees supplemental life covered amount)**
☐ **Waive Coverage**

Child(ren) Supplemental Life Insurance

☐ **$5,000** ☐ **$10,000** ☐ **Waive Coverage**

***Guarantee Issue Limit for Supplemental Employee Life Insurance is equal to 2 times salary with a max of $200,000; $50,000 for Dependent Spouse Insurance; and $10,000 for Dependent Child Insurance. Guaranteed coverage is only available during new employee's initial enrollment. All elections in excess of these amounts require satisfactory statement of insurability. Late entrants must provide satisfactory evidence of insurability before any supplemental elections go into effect. See your benefits manager for the forms.**

Please refer to the Benefit Summary details concerning your options

Beneficiary Designation: Basic and Supplemental Coverage

Primary Beneficiary	Percentage	Relationship to Insured
Contingent Beneficiary	**Percentage**	**Relationship to Insured**

Additional Beneficiaries should be listed on the back of this form. The employee is automatically the beneficiary for the dependent coverage.

C. INFORMATION FOR DEPENDENT COVERAGE

Last name First Name M.I.	Date of Birth	Relationship	If child is over age 19, please indicate status and/or school	Gender	Check one
			☐ Handicapped ☐ Student at	☐M ☐ F	☐ Enroll ☐ Cancel ☐ Waive ☐ Change
			☐ Handicapped ☐ Student at	☐M ☐ F	☐ Enroll ☐ Cancel ☐ Waive ☐ Change
			☐ Handicapped ☐ Student at	☐M ☐ F	☐ Enroll ☐ Cancel ☐ Waive ☐ Change

D. SIGNATURE (THIS FORM MUST BE SIGNED)

I understand that by signing this form that I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected.

X _____ _____

Signature **Date**

E. EMPLOYER USE ONLY

☐ Initial enrollment following Date of Hire ☐ Late Applicant	Employee Effective Date (mm/dd/yyyy)	Signed for Employer by	Group Number

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