

ENROLLMENT • CHANGE FORM

GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)				
Name of Group Customer/Employer Old Dominion University Research Foundation	Group Customer # 104994	Report # 104994	Sub Code	Branch
Date of Hire (MM/DD/YYYY)	Coverage Effective Date (MM/DD/YYYY)			

YOUR ENROLLMENT INFORMATION (To be Completed by the Employee)			
Name (First, Middle, Last)		Social Security # - -	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street, City, State, Zip Code)		Date of Birth (MM/DD/YYYY)	
Phone #	Email Address	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Change in Enrollment If due to a Qualifying Event, enter date (MM/DD/YYYY)	
<p>I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that no contributions are required for Basic Life, Basic AD&D, and the Long Term Benefits. I understand that contributions are required for the benefits I select below.</p> <p>▶ If you are enrolling during the initial enrollment period, you must complete a Statement of Health form:</p> <ul style="list-style-type: none">• If you are enrolling for Supplemental/Optional Life Insurance and requesting more than \$140,000• If you are enrolling for Dependent Spouse Life Insurance and requesting more than \$25,000 <p>If you are enrolling after the initial enrollment period, you must also complete a Statement of Health form for all amounts you are requesting.</p>			
Term Life Insurance			

Basic Life ¹

Supplemental/Optional Life ¹

Enter a multiple of \$10,000 up to a maximum of the lesser of 5x your Basic Annual Earnings or \$500,000. \$ _____

Dependent Spouse Life ^{1,2}

Enter a multiple of \$5,000 up to a maximum of \$250,000. \$ _____

SUBMISSION INSTRUCTIONS

After completion, make a copy for your records and return the original to your Employer.

