

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

APPLICANT	Your Name (Last, First, Middle)		Group Name Rector and Visitors of the University of Virginia		Group Number(s) 137985	
	Your Address		City		State	ZIP
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation	
LIFE	<p><i>Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.</i></p> <p>Basic Life Insurance <input checked="" type="checkbox"/> Basic Life with AD&D Employer Paid</p> <p>Optional Life (<i>You must make a selection</i>) Option 1: <input type="checkbox"/> \$50,000 Option 2: <i>Option 2 is in addition to Option 1; you must select Option 1 to be eligible to elect Option 2.</i> <input type="checkbox"/> \$25,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 Option 3: <input type="checkbox"/> 1 Times Annual Salary <input type="checkbox"/> 2 Times Annual Salary <input type="checkbox"/> 3 Times Annual Salary <input type="checkbox"/> 4 Times Annual Salary <input type="checkbox"/> Decline Optional Life Options</p> <p>Dependents Life Insurance (<i>You must make a selection</i>) Spouse coverage: <input type="checkbox"/> 1 Times Employee Annual Salary <input type="checkbox"/> 2 Times Employee Annual Salary <input type="checkbox"/> Decline Spouse Life Insurance Options Child coverage: <input type="checkbox"/> \$10,000 <input type="checkbox"/> Decline Child Life Insurance Option</p>					
	<p><i>Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.</i></p> <p>Long Term Disability <input checked="" type="checkbox"/> Employer Paid LTD with Monthly Annuity Premium Benefit (MAPB)</p>					
BENEFICIARY	<p><i>This designation applies to Life Insurance available through your Employer, if any. Unless specified otherwise on a separate sheet of paper, this designation will also apply to Supplemental Life Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.</i></p>					
	Primary - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
	Contingent - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit
CHANGE	<p>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</p> <p><input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Name Change <input type="checkbox"/> Beneficiary Change Date of add/delete _____ Former name _____ <input type="checkbox"/> Other _____</p>					
	<p>I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. If declining coverage, I understand that if I want to become insured later, I will be required to provide The Standard with satisfactory Evidence Of Insurability, and that The Standard will have the right to refuse my request for insurance. I understand that coverage(s) not specifically elected will not become effective, even if not marked as declined above.</p>					
SIGNATURE	Member/Employee Signature Required				Date (Mo/Day/Yr)	
<p>Human Resources Department - Complete this section. Retain form for your records.</p>						
Dvsn ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings \$ _____	Per: Hour	Wk Mo Yr

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
 1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
 2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
 3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, “Dorothy Q. Smith, Trustee under the trust agreement dated _____.”
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer’s coverage under the Group Policy.