



**ASSOCIATED UNIVERSITIES, INC.
NATIONAL RADIO ASTRONOMY OBSERVATORY
Dependent Life Insurance Enrollment Form**

Employee Information

Name: _____ Employee #: _____ Eff Date: _____
 Street: _____ City: _____ State: _____ Zip: _____
 New Enrollment: Coverage Change Monthly Biweekly

SPOUSE
 Spouse coverage must be elected in \$5,000 increments and cannot exceed 50% of employee's supplemental election. New Hires: The first \$30,000 of spouse coverage is Guaranteed Issue. Changes or additional amounts over \$30,000 will require evidence of insurability.

Full Name _____ DOB _____ Gender _____ SSN _____
 M F
 Life Insurance Amount (\$5,000 increments, includes AD&D): \$ _____

CHILD(REN)
 Child coverage must be elected in \$2,000 increments and cannot exceed \$10,000. Coverage for children is always Guaranteed Issue. Coverage remains in effect until 26th birthday. Children under 6 months are only eligible for \$500 of coverage.

Full Name _____ DOB _____ Gender _____ SSN _____
 M F
 Life Insurance Amount (\$2,000 increments, includes AD&D): \$ _____

Full Name _____ DOB _____ Gender _____ SSN _____
 M F
 Life Insurance Amount (\$2,000 increments, includes AD&D): \$ _____

Full Name _____ DOB _____ Gender _____ SSN _____
 M F
 Life Insurance Amount (\$2,000 increments, includes AD&D): \$ _____

Full Name _____ DOB _____ Gender _____ SSN _____
 M F
 Life Insurance Amount (\$2,000 increments, includes AD&D): \$ _____

I accept the insurance coverages elected above. If premiums are to be paid by payroll, I authorize Associated Universities, Inc. to deduct the necessary amounts from my earnings.

 Employee Signature _____ Date _____

HR USE ONLY

Election above Guaranteed issue: \$ _____
 Premium Calculation Sheets attached? Yes No Notes: _____
 HR Authorization: _____ JDE