ASSOCIATED UNIVERSITIES, INC.

PAYROLL DEDUCTION AUTHORIZATION FOR LIFE & DISABILITY INSURANCE

Name _____ Employee No. _____ Birth date _____

New Employee ☐ Beneficiary Change ☐ Coverage Change ☐ Effective Date _____

GROUP LONG TERM DISABILITY INSURANCE

All employees are required to participate in Long Term Disability Insurance.

I understand that I will be automatically enrolled in payroll deduction for LTD coverage Initials: _____

GROUP LIFE INSURANCE

Basic Life, Basic AD&D- Automatic Enrollment- No Cost

Supp. Life 1x, Supp. AD&D 1x ☐ Supp. Life 3x, Supp. AD&D 3x ☐ Supp. Life 5x, Supp. AD&D 5x ☐

Supp. Life 2x, Supp. AD&D 2x ☐ Supp. Life 4x, Supp. AD&D 4x ☐ No Supplemental Life/AD&D ☐

I hereby authorize deductions from my salary for the coverages accepted above. I verify (1) that the information I have provided is accurate and complete, and (2) the beneficiary(ies) that I have designated are correct. I understand that if I refuse the life, accidental death and dismemberment and/or the long term disability coverage(s) and request to purchase such insurance at a later date; (1) I will be required to furnish evidence of insurability for myself and/or my dependents at my own expense; and (2) the carrier will have the right to refuse my request.

_____ _____

Employee Signature Date

Will the requested insurance replace existing life insurance? ☐ Yes ☐ No

Employee Signature _____

Are you aware the requested insurance replaces existing life insurance? ☐ Yes ☐ No

Agent Signature _____

LIFE INSURANCE BENEFICIARY RECORD

Unless otherwise provided, where two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the Insured, or to the survivor or survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the policy.

BASIC LIFE POLICY Including Accidental Death & Dismemberment Insurance (Attach additional page if needed)	**SUPPLEMENTAL POLICIES** Including any elected Accidental Death & Dismemberment Insurance (Attach additional page if needed)
Primary Beneficiary(ies) Name Relationship Address	**Primary Beneficiary(ies)** Name Relationship Address
Contingent Beneficiary(ies) Name Relationship Address	**Contingent Beneficiary(ies)** Name Relationship Address

I reserve the right to make further changes in my beneficiary designation.

_____ _____

Employee Signature Date

GEF-00456-0804 VA