



# NATIONAL RADIO ASTRONOMY OBSERVATORY 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

*Employees age 30 or over are required to participate in Long Term Disability Insurance.*

I accept:  Immediate coverage  Upon attaining age 30 Effective Date \_\_\_\_\_

## GROUP LIFE INSURANCE

Basic Life, Basic AD & D	Automatic Enrollment - No Cost
Supplemental Life I, Supplemental AD & D I	Accepted <input type="checkbox"/> Refused <input type="checkbox"/>
Supplemental Life II, Supplemental AD & D II	Accepted <input type="checkbox"/> Refused <input type="checkbox"/>

*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)

#### Primary Beneficiary(ies)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

#### Contingent Beneficiary(ies)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

### SUPPLEMENTAL I & II POLICIES

Including any elected Accidental Death & Dismemberment Insurance  
(Attach additional page if needed)

#### Primary 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