

# The Texas A&M University System Life Insurance Enrollment Form



*With few exceptions, you have the right to request, receive, review and correct information about yourself collected using this form.*

1. Name \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
*Last (please print) First MI*

2. Social Security number or UIN  
\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_-\_\_\_\_\_

3. If you have a spouse/parent/child who currently works for The Texas A&M University System, please provide his/her name \_\_\_\_\_ and Social Security number \_\_\_\_\_

### BASIC LIFE/ALTERNATE BASIC LIFE

**If enrolling for the first time:** *If you do not have A&M System health coverage but certify that you have other health coverage, you may have Alternate Basic Life or Optional Life, but not both.*

- 4. I do not have health coverage but want to enroll in Basic Life \_\_\_\_\_.
- 5. I have certified that I have other health coverage, and I wish to enroll in Alternate Basic Life coverage. Yes \_\_\_ No \_\_\_
- 6. I have designated the following primary beneficiary(ies) (attach an additional sheet if necessary):

<i>Name</i>	<i>Relationship</i>	<i>Distribution by %</i>	<i>Address (Street/P.O. Box, City, State, ZIP)</i>

7. I have designated the following secondary beneficiary(ies) (attach an additional sheet if necessary):

<i>Name</i>	<i>Relationship</i>	<i>Distribution by %</i>	<i>Address (Street/P.O. Box, City, State, ZIP)</i>

**If increasing coverage:** 8. I want to increase Alternate Basic Life to \$ \_\_\_\_\_ . (maximum coverage is \$50,000)

### OPTIONAL LIFE

*You may not enroll in Optional Life if you are covered under Dependent Life by a spouse who works for the A&M System. If you do not have A&M System health coverage but certify that you have other health coverage, you may have Alternate Basic Life or Optional Life, but not both. If you are enrolling for the first time, you must complete items 11–13.*

- 9. Employee: I want the following coverage (circle one):    ½    1    2    3    4    5    6    times my annual salary.
- 10. Retiree: I want the following coverage amount: \$ \_\_\_\_\_ (You may choose any multiple of \$1,000 up to \$60,000)
- 11. I have \_\_\_ have not \_\_\_ used any tobacco products within the past 12 months.
- 12. I have designated the following primary beneficiary(ies) (attach an additional sheet if necessary):

<i>Name</i>	<i>Relationship</i>	<i>Distribution by %</i>	<i>Address (Street/P.O. Box, City, State, ZIP)</i>

13. I have designated the following secondary beneficiary(ies) (attach an additional sheet if necessary):

<i>Name</i>	<i>Relationship</i>	<i>Distribution by %</i>	<i>Address (Street/P.O. Box, City, State, ZIP)</i>

**Please read the following and sign below.**

**Payroll Deduction/Billing Agreement:** I authorize The Texas A&M University System to deduct from my earnings the amount required to cover my share of the premiums for these coverages. If I am being billed, I understand that failure to pay my premium(s) will result in cancellation of coverage.

**Witness's Signature:** The witness line must be completed if you have named any beneficiaries on this form. The witness cannot be your beneficiary or a member of your family, and the date of the witness' signature must be the same as yours.

Date Stamp

\_\_\_\_\_  
*Signature of witness in ink (blue preferred)      Witness's name (printed)      Signature date*

\_\_\_\_\_  
*Signature of employee/retiree in ink (blue preferred)      Daytime phone number      Signature date (MM/DD/YYYY)*