Nationwide Life Insurance Company	Commonwealth of Kentucky
Home Office: Columbus, Ohio	Employee Group Life Insurance Program
	Enrollment/Change/Termination Form
	Group Insurance Contract: 90002

SSN	Location Name (Specify name or Agency, School Board or Health Dept.)		
Name (Last, First, MI)	Location Number	Birth date	
Address (Street Name/Number)	Annual Salary	Hire Date	Gender ☐Male ☐Female
(City, County, State, Zip)	Work Number	Home Number	

☐ **Termination**: Date Employment Ends _________________ Date Life Insurance Terminates ____________________

Reason: ☐ Resigned ☐ Retired ☐ LWOP ☐ Death ☐ Military Leave ☐ Other _________________

☐ **Reinstate Coverage:** Date Returned to Work _________________ Date Insurance Effective _________________

Reason: ☐ Rehired ☐ FMLA ☐ LWOP ☐ Military Leave ☐ Other __________________

☐ **Transfer or Summer Transfer**

- To be completed by the **NEW** company

Prior Company Number	New Company Number
Last Day Worked at Prior Company	Date Hired at New Company
Coverage End Date at Prior Company	Coverage Begin Date at New Company

A. Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Eligible employees are insured at no cost to the employee for Basic Life and AD&D Insurance

All Eligible Employees $20,000 Cost: (employer paid)

B. Optional Life and Accidental Death and Dismemberment (AD&D) Insurance (Select One Plan)

I wish to ______enroll* in, ______change* to, ______terminate the optional insurance plan checked below:

Monthly Contribution

Age Band	Rate per $1,000
Under 40	$0.26
40-59	$0.60
60 and over	$0.94

☐ Plan 1 $5,000	☐ Plan 2 $10,000
☐ Plan 3 100% of annual earnings**	☐Plan 4 200% of annual earnings**

*Evidence of insurability may be required depending on the circumstances and/or for insurance over $150, 000.

**Under Plans 3 and 4, insurance amounts will be rounded to the nearest multiple of $1,000. Amounts of insurance will increase with an earnings change.

C. Dependent Life Insurance (Select One Plan)

Please ___ enroll* my dependents in, ___ change* my present plan to, or ___ terminate the plan checked below:

	☐ Plan A	☐ Plan B	☐ Plan C	☐ Plan D	☐ Plan E
Spouse**	$10,000	$5,000	$5,000	$10,000	---
Dependent Children to 6 mos	$2,500	$1,500	---	---	$2,500
Dependent Children 6 mos to 18 yrs***	$5,000	$3,000	---	---	$5,000
Monthly Contribution	$11.46	$6.20	$2.62	$9.14	$3.78

***Evidence of insurability may be required depending on circumstances**

**** Spouse means a person to whom you are legally married**

***** 18 and older if attending an educational institution and relying on the employee for financial support or incapacitated and proof received within 31 days of age limit**

D. **Waiver of Optional Life and Dependents Coverage**

☐ I certify that I have been given the opportunity to enroll my self and my eligible dependents in the above coverage. I have declined the Optional and/or Dependents Life coverage and understand that it will be necessary for me and my dependents to furnish evidence of insurability if I desire any of the above coverage in the future (other than during an open enrollment period or other exception detailed in the certificate booklet).

E. Fraud Warning: Any Person who knowingly and with intent to injure, defraud, or deceive an insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss of benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

F. Employee Signature and Date (Required)

I, the undersigned, certify that I have read the completed enrollment/change/termination form and agree that all answers in this form are true and complete to the best of my knowledge and belief. I hereby authorize my employer to deduct from my paycheck or earnings the amount required to cover my share of the coverage I have selected.

Employee Signature ____ **Date** ____________________________

IC/HRG Signature____ **Date**____________________________

Send Copy to your Insurance Coordinator

2012

Within thirty-five (35) days from their date of hire, new employees may enroll in group life insurance online by using the KHRIS Employee Self Service Center (ESS).

Instructions

- Print all information using black or blue ink (if submitting a paper form.)
- An enrollment is required for employees designating Basis Life and AD&D Insurance (choice A).
- Complete location name and number.
- Annual earnings are required when selecting Optional Plan 3 or 4.
- Select only one plan for Optional Term Life coverage.
- Select only one plan for Dependent Term Life coverage.
- Employee must provide evidence of insurability for coverage over $150,000. This must be approved by the insurance carrier before coverage can be initiated.
- Spouse is defined as a person to whom you are legally married.
- Child 18 or older can remain covered providing the child is a full-time student and relying on the *employee for financial support* or incapacitated and proof received within 31 days of age limit
- Employee signature and date is required (if submitting a paper form.)
- Description of Qualifying Event should be completed by the Insurance Coordinator. For example: Marriage only.
- Date of Qualifying Event should be listed as the last day employee worked or official date of termination, not when coverage will end.

For Board of Education employees with salary based plans, the new contract year salary will be effective 11/1 of each year.

<u>Premium rates are current as of January 1, 2012. Rates may change as the insured enters a higher age category or if the plan experience requires a change for all insured.</u>

On Your Side®

Nationwide Life Insurance Company

Home Office: Columbus, Ohio

Nationwide Employee Benefits SM
Group Life and Accidental Death
Designation of Beneficiary Form

Submit Form to: Personnel Cabinet- Group Life Administration, 501 High Street, 3rd Flr, Frankfort, KY 40601

Section 1: Insured Information (Please complete all appropriate boxes in ink, printing legibly.)	
Group Name **Commonwealth of Kentucky**	Group Number **90002**
Employee Name (First, Middle Initial, Last)	Social Security Number

Subject to the terms and conditions of the above referenced Group Number, I request that any sum becoming payable by reason of my death be payable to the following beneficiary (ies). It is my understanding that this designation shall operate so as to revoke all designations of beneficiary (ies) previously made by me under the Group Policy.

Employee Signature (Required)	Date (Required)

Note: Beneficiary designation is not valid unless this form and any separate accompanying sheets are signed and dated.

Section 2: Beneficiary Designation/Change (Please complete all appropriate boxes in ink, printing legibly. If you do not designate one or more beneficiaries, policy proceeds will be paid to your estate unless otherwise regulated by law.

Basic Life and AD&D

Primary Beneficiary Information (Allocation to all Primary Beneficiaries must equal 100%)

Beneficiary Name and Address	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit

Contingent Beneficiary Information (Allocation to Contingent Beneficiaries must equal 100%)

Beneficiary Name and Address	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit

Optional Life and AD&D

Primary Beneficiary Information (Allocation to all Primary Beneficiaries must equal 100%)

Beneficiary Name and Address	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit

Contingent Beneficiary Information (Allocation to Contingent Beneficiaries must equal 100%)

Beneficiary Name and Address	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit

Section 3: General Information

- If more room is needed to indicate additional primary or contingent beneficiaries, please attach a separate sheet and list the information indicated above for each beneficiary. Please sign and date all additional sheets as well as this original form.
- Your group life coverage is issued by Nationwide Life Insurance Company, One Nationwide Plaza, MR-05-11 Columbus, OH 43215. Please refer to the Certificate of Insurance and Insurance Contract for all plan details, including any exclusions, limitations and restrictions which may apply.

Designation of Beneficiary (may be completed on-line using KHRIS Employee Self Service Center)

Instructions

- Print all information using black or blue ink.
- If additional space is needed, a separate paper listing all beneficiary information may be included. This paper must be signed and dated the same as the original form.
- Complete location name.
- Employee signature and date is required.
- Include the relationship of the beneficiary to the employee and the percentage of benefit to be paid.
- One or more beneficiaries may be named. If you do not name a beneficiary, or if you are not survived by one, benefits payable because of your death will be paid in equal shares to the first surviving class of the following: (a) Your spouse, (b) Your children, (c) Your parents, (d) Your brothers and sisters, and (e) Your estate. If utilizing KHRIS ESS, the Designation of Beneficiary will be effective immediately upon submission. If utilizing the paper form, the Designation of Beneficiary is not valid unless the form is signed and dated.
- The Designation of Beneficiary must be on file with your Employer and/or Life Insurance Branch at the time of your death to be accepted. KHRIS requires that all percentages be whole numbers. For example, an employee can no longer list 3 beneficiaries at 33 1/3% each. It must be entered as 33%, 33% and 34%. The percentages shall total 100%. Beneficiaries may be named or changed at any time without the consent of a beneficiary.
- If a trust or trustee is named beneficiary, the written trust must be identified in the beneficiary designation. For example, “Dorothy Q. Public, Trustee under the trust agreement dates _____.” Show name and address of the trustee and effective date of the trust agreement.
- Insurance Coordinator should *verify all information*.