



Please return completed form to your benefits department

Employer Name	Group Policy Number
Smith College	01-B6W120
Employer Address (City, State, ZIP Code)	Coverage Effective Date

Employee Name (Last, First, Middle)			
Address (City, State, ZIP Code)			
Social Security Number	Date of Birth (MM/DD/YY)	Gender	Marital Status
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Married <input type="checkbox"/> Widowed
Hire Date (MM/DD/YY)	Annual Salary	Type of Enrollment	
	\$	<input type="checkbox"/> New Employee <input type="checkbox"/> Qualified Life Event	<input type="checkbox"/> Annual/Open Enrollment <input type="checkbox"/> Rehire Rehire Date:

Coverage Elections

Please indicate your coverage elections below.

The Employee must enroll in Supplemental Life coverage to elect Supplemental Dependent Life coverage. The Supplemental Spouse Benefit cannot be greater than 50% of the Employee Supplemental Benefit.

Evidence of Insurability is required for amounts over 3x annual earnings for employee or \$40,000 for Spouse. Please see your plan booklet for additional information.

Type of Coverage	Selection	Coverage Elected
Employee Basic Life and AD&D (Employer Paid)	<input checked="" type="checkbox"/> Yes	1 times earnings to a maximum of \$500,000
Employee Supplemental Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> 1x <input type="checkbox"/> 2x <input type="checkbox"/> 3x <input type="checkbox"/> 4x <input type="checkbox"/> 5x Earnings
Spouse Supplemental Life (You may elect in increments of \$10,000 to a maximum \$140,000.)	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Child(ren) Supplemental Life	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000

If electing for Dependent coverage (Spouse and Child), please complete the following:	
Spouse Name:	Date of Birth:
Child Name:	Date of Birth:
Child Name:	Date of Birth:
Child Name:	Date of Birth:
Child Name:	Date of Birth:
Dependent Child(ren) coverage is available to eligible dependent child(ren) under 26 years of age.	

Please complete page 2.

Submit completed form to your employer and retain a copy for your records.

Employee Signature and Authorization

ACCEPT: I declare that all information given in this enrollment form is true and complete to the best of my knowledge and belief. I request coverage under my employer's plan of benefits as indicated above. I authorize my employer to deduct from my earnings my contributions for the coverage(s) selected. I understand that with respect to coverages I have declined, Liberty Mutual Insurance has the right to require Evidence of Insurability in order to consider any later request to change this decision and that my request may be denied. I am an employee in active employment working at the employer's regular place of business.

DECLINE: I hereby decline all Supplemental coverage as offered by my employer. I certify that I have been given the opportunity by my employer to enroll for coverage. I understand that Liberty has the right to require Evidence of Insurability in order to consider any later request to change this decision and that my request may be denied. I am an employee in active employment working at the employer's regular place of business.

Employee Signature: _____ Date: _____

Completion of this enrollment form does not guarantee coverage. Evidence of Insurability may be required. Please see your plan booklet for additional information.

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