

APPLICATION FOR COVERAGE GROUP LIFE INSURANCE

EMPLOYEE

Submit this Application to your employer within 31 days of becoming eligible for Group Life Insurance. Your employer will complete the "Employer" section below and forward the completed application to the Group Life Insurance Program.

Employee's Name: _____ Social Security #: _____

Employee's Mailing Address: _____

Date of Birth: _____ ☐ Male ☐ Female

☐ I would like the coverage(s) checked below. ☐ I refuse all coverage.

☐ **BASIC:** Equals my gross salary rounded up to the next highest \$1,000

☐ **SUPPLEMENTAL:** ☐ One (doubles your Basic) ☐ Two (triples your Basic) ☐ Three (quadruples your Basic)

☐ **DEPENDENT PLAN A***

Spouse	\$ 5,000
Children, birth to 6 months of age	\$ 1,000
Children, 6 months to age 19	\$ 5,000
Unmarried, full-time students to age 22	\$ 5,000

☐ **DEPENDENT PLAN B***

Spouse	\$10,000
Children, birth to 6 months of age	\$ 2,500
Children, 6 months to age 19	\$ 5,000
Unmarried, full-time students to age 22	\$ 5,000

☐ Check this box if you are not electing Dependent coverage at this time, BUT have dependents eligible for coverage.

*A spouse or child insured under the Group Life Insurance Program as an employee or a retiree cannot be insured as a dependent of a participant. If both parents of a child are insured under the Program, only one parent may purchase dependent coverage for that child. If you have selected Dependent Plan A or Plan B, provide the following information:

Spouse's Name: _____ Date of Birth: _____
Spouse's Social Security #: _____



EMPLOYEE SIGNATURE

DATE

DESIGNATION OF BENEFICIARY

Employees should complete the Designation of Beneficiary - Group Life Insurance (GI-0912) form when applying for Group Life Insurance coverage. The form is available from the employer, from MainePERS, or by download from the MainePERS Web site at www.mainebers.org.

EMPLOYER

Employer Name: _____ Employer Code: _____

Department: _____ Employer Telephone #: _____

Personnel Status/Code: _____ Position Code: _____ Annual Salary: _____

Date applicant first eligible for Group Life Insurance Coverage: _____

The above information relating to present employment is true and correct to the best of my knowledge.

SIGNATURE OF EMPLOYER'S CERTIFYING OFFICIAL: _____ DATE _____

PRINT OR TYPE NAME AND TITLE OF CERTIFYING OFFICIAL: _____

DESIGNATION OF BENEFICIARY GROUP LIFE INSURANCE

Please see *Instructions* for information regarding your designation. Retain a copy for your records.

EMPLOYEE

Social Security Number:		Gender: ☐ M ☐ F	Date of Birth:			
				Month	Day	Year
Home E-mail Address:						
Name:						
	First	Middle	Last	Suffix		
Mailing Address:						
	Street or Box Number	City/Town	State	ZIP Code		

DESIGNATION OF BENEFICIARY - PRIMARY

Name(s) of Primary Beneficiary(ies):	Social Security Number (required):	Date of Birth (required):	Relationship (required):	% to Receive (must total 100%):

DESIGNATION OF BENEFICIARY - CONTINGENT

Name(s) of Primary Beneficiary(ies):	Social Security Number (required):	Date of Birth (required):	Relationship (required):	% to Receive (must total 100%):

Note: Contingent beneficiaries will be paid only if primary beneficiaries pre-decease you.

I hereby designate the beneficiary(ies) named above, if they survive me, to receive any amount of Group Life Insurance and Group Accidental Death Insurance payable at my death. This designation invalidates all previous Designations of Beneficiary and applies to all MainePERS Group Life Insurance Program policies issued to me. This designation will remain in effect until cancelled by me in writing on an appropriate form filed with the MainePERS.

EMPLOYEE SIGNATURE _____

DATE _____

Use this form to designate or change your beneficiary(ies) under the Group Life Insurance Program administered by the Maine Public Employees Retirement System (MainePERS).

This form does not pertain to MainePERS pre-retirement death benefits. You must change your beneficiary(ies) for your MainePERS pre-retirement death benefits separately by completing the form *Designation of Beneficiary Pre-Retirement Death Benefits* (Form#: CL-0722).

INSTRUCTIONS

THE DESIGNATION OF BENEFICIARY GROUP LIFE INSURANCE FORM

1. The Primary Beneficiary(ies) you name, if living, will receive your insurance benefit at the time of your death. If the Primary Beneficiary(ies) are deceased at the time of your death, the Contingent Beneficiary(ies) you name will receive the benefit.
2. The Employee Signature and Date must be completed for this form to be legally binding.
3. If more than one beneficiary is to share the proceeds, payment will be made in equal shares unless you specify otherwise on this form (in the "Percentage to Receive" space). Specify different shares by fractions or percentages rather than dollar amounts.
4. If you wish money to go to an organization, designate your Estate as your beneficiary and outline your wishes in your will.
5. When a beneficiary is not related, state the relationship as "non-relative."
6. If you need more room, attach additional sheets, specify the type(s) of beneficiary(ies) you are naming, and include all requested information. Each additional sheet must be signed and dated to be legally binding.
7. Your Designation of Beneficiary form will be invalid to you if:
 - you do not sign and date the form
 - the form has been altered or is not legible
 - the form references another document or contains "and/or" or "or" in the designation
 - the designation lists only the first names of the beneficiaries
8. You have the right to change your beneficiary designation(s) at any time, without the consent of any person, by filing a new Designation of Beneficiary form. At your death, your life insurance benefit will go to the beneficiary(ies) named on your most recent Designation of Beneficiary form if the signed and dated form was postmarked before your death.
9. If completing Application for Coverage and Beneficiary form, return completed forms to your Employer.

If completing Beneficiary form only, mail the completed form to:

Maine Public Employees Retirement System
Attn: Survivor Services
46 State House Station
Augusta, ME 04333