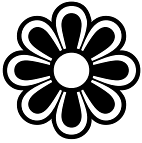

State of Mississippi

Active Employee Enrollment Form / Change form for Basic Life Insurance

Policy #537377-022

Employee Name (Last name, first, middle initial)	Social Security Number
Employee Address (street, city, state, zip code)	Date of Birth

Gender ☐ Male ☐ Female	Date of Employment	Annual Earnings
Employer **TUPELO PUBLIC SCHOOL DISTRICT**		Occupation

Employee Life Insurance Amount: $____________________________

Eligible Active Employees receive coverage of two times annual salary rounded to next highest $1,000, subject to a minimum of $30,000 and a maximum of $100,000.

Note: All employees are automatically covered for Basic Life and AD&D unless a waiver is signed. (waiver on back of this form)

I am: ☐ **New Enrollee** ☐ **Late Enrollee (Evidence of Insurability is required)** ☐ **Changing Beneficiary**

☐ **Changing Name (previous name ____)** ☐ **Adding Dependent(s)**

Beneficiary Information

Designate your beneficiary (ies) for your Basic Life Insurance coverage below:

Name	Relationship to You		Benefit %
		Primary ☐ Contingent ☐	
		Primary ☐ Contingent ☐	
		Primary ☐ Contingent ☐	
		Primary ☐ Contingent ☐	

If no primary beneficiary (ies) survive you, the proceeds will be paid to the surviving contingent beneficiary (ies).

I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available at my request. I hereby authorize my employer to deduct the appropriate life insurance premium, monthly. I also authorize my employer to forward payment of such premium amount to UNUM or its authorized agent / representative on the first working day of each month to cover the cost of my life insurance carried by me. I understand that UNUM and / or its authorized agent / representative are responsible for billing my employer monthly for the appropriate premium amount. I further understand that I am responsible for notifying UNUM and / or its authorized agent / representative concerning cancellation, premium changes, policy questions, and / or general information. Employee and Dependents must be actively at work and not disabled for coverage to be effective.

Employee Signature	Date	Work Phone	Home Phone