Department Name: _____

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO

ENROLLMENT FORM FOR HSC GROUP LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

FOR SCHOOL OF MEDICINE HEALTH SCIENCES COMPENSATION PLAN FACULTY ONLY

IMPORTANT

An Evidence of Insurability Form and Health Statement must accompany this application in the following cases:

- Application for an *increase* in voluntary coverage after the initial 31-day period
- Reapplication for any previously declined additional coverage

THIS SECTION TO BE COMPLETED BY FACULTY MEMBER

FACULTY MEMBER INFORMATION

NAME: _____
Last First Middle Initial

EMPLOYEE ID NO.: _____ BIRTHDAY: _____
mm-dd-yy

SOCIAL SECURITY NO.: _____ Sex: M ☐ F ☐

BASIC COVERAGE

Equal to 2 X your annual supplemental (i.e., Y) earnings. This coverage is employer-paid.

☐ CHECK HERE IF YOU PREFER BASIC COVERAGE *ONLY*

VOLUNTARY COVERAGE

You may apply for additional coverage as follows. This employee-paid coverage is *in addition* to the employer-paid coverage described above. CHECK DESIRED COVERAGE OPTION:

☐ 1 X YOUR ANNUAL SUPPLEMENTAL (i.e., Y) EARNINGS
☐ 2 X "
☐ 3 X "
☐ 4 X "

BENEFICIARY

(If there is more than one beneficiary, attach a separate, signed sheet)

NAME: _____

ADDRESS: _____

THIS SECTION TO BE COMPLETED BY DEPARTMENT IN SCHOOL OF MEDICINE

FACULTY MEMBER INFORMATION

ANNUAL SUPPLEMENTAL INCOME: $_____

EFFECTIVE DATE

BASIC LIFE _____ VOLUNTARY LIFE _____
mm-dd-yy mm-dd-yy

TRANS CODE	EMPLOYEE I.D. NO.	EFFECTIVE DATE	ELEMENT NO.	BAL. CD	AMOUNT
1 2	4 12	13 18	19 22	23	24 30

APPROVAL

DEAN'S OFFICE: _____

DATE: _____

I hereby (1) request that coverage for which I am eligible under the above group policy (policies) issued by the Assurant Benefits Insurance Company; (2) authorize the required deductions, if any, from my earnings; (3) designate the beneficiary named on this form to receive the benefits, if any, payable in the event of my death; and (4) certify that the above birth dates are correct.

Signature _____ Date _____