maine PERS Public Employees Retirement System

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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: Prefix | First | MI | Last | Suffix

Social Security Number: Date of Birth: mm dd yyyy ☐ Male ☐ Female

Mailing Address: Street/PO Box | City/Town | State | ZIP

☐ 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 or a participant. If both parents or 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: Prefix | First | MI | Last | Suffix

Social Security Number: Date of Birth: mm dd yyyy

Employee Signature: _____ Date: _____

Designation of Beneficiary

Employees should complete the Desgination 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.mainepers.org**.

Employer

Employer Location Code: Employer Location Name:

Employer Phone #: Personnel Status/Code: Position Code:

Annual Salary: Date applicant first eligible for Group Life Insurance: mm dd yyyy

Certifying Signature

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

_____ Certifying Official Signature

_____ Date

_____ Print/Typed Name

_____ Phone #

_____ E-mail

PLEASE RETAIN A COPY FOR YOUR RECORDS