

Enrollment Form Group Policy No. 877075

1. Employee Information
Name (first middle last) Eagle ID
Home Address Telephone Numbers Date of Hire Date of Birth
Campus Ext. Home# ( ) Male Female

2. Request for Dependent Life Insurance [IMPORTANT - First Read Instructions on Reverse]
Circle the Units of Dependent Insurance you currently have: None 1 2 3
Select the TOTAL number of Units you now wish to have:
Either 1 Unit (Spouse \$10,000; Each Child \$5,000)
Or 2 Units (Spouse \$20,000; Each Child \$10,000)
Or 3 Units (Spouse \$30,000; Each Child \$15,000)
(For Benefits Use) Effective Date

3. Eligible Dependents to be Insured
Name (first middle last) Date of Birth Relationship
Spouse
Child
Child
Child
Child

4. Certification and Authorization
I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all the terms of the Plan of Insurance contained in the group policy and summarized in the announcement material provided to me and the certificate issued to me.
I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the Plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent. I understand that, if I fail to sign this form within 60 days of my date of eligibility, my and my dependents' eligibility may be affected.
I request my employer to arrange for the issuance of Group Life Coverage for which I am or may become eligible, and I authorize deductions of the required contributions from my earnings. This authorization applies to the Plan until rescinded by me in writing.
[Misrepresentation: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or, for the purpose of misleading, conceals information concerning any fact material thereto, commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.]
Employee Signature Date
Boston College Authorization Date

## **Dependent Life Insurance**

### **Enrollment Form Instructions**

Dependent coverage is available in one to three “units.” Each unit of insurance covers your spouse and/or eligible children. An eligible child is an unmarried child who is over 14 days old, but under 23 years of age. Your children include your biological children, your adopted children, your stepchildren, and any other children you support who live with you in a parent-child relationship. Children who are handicapped when reaching the limiting age of 23 may be eligible to continue their coverage with approval from Aetna. [**Note:** No person may be covered as a dependent of more than one employee. Also, a spouse and/or child may not be covered as a dependent if the spouse and/or child is an employee of Boston College and is eligible for Supplemental Life coverage through the Boston College plan.]

**1. Employee Information** - Complete as indicated.

**2. Request for Dependent Life Insurance**

Circle the answer for the number of units you currently have.

Indicate the total number of units desired, including the number already in effect, if any. If you are a new employee, you may elect 1 unit of Dependent Insurance within 60 days of your hire date without submitting evidence of good health. Two or three units require an Evidence of Insurability Statement for your spouse and eligible dependents.

If you are a current employee and you already have 1 or 2 units of insurance, you may elect one additional unit during the Open Enrollment period without submitting evidence of good health.

If you are a current employee not participating in the plan and you would like 1 or more units, an Evidence of Insurability Statement will be required for your spouse and your dependents.

**Insurance requests requiring health information become effective only after approval by Aetna.**

If you are a participating employee, and wish to add newly eligible members (e.g., due to marriage, birth of a child, etc.) your coverage may default to the lowest number of eligible units available without additional health information. Please discuss coverage options and requirements with the Benefits Office, 2-3329.

**3. Eligible Dependents to be Insured**

List the names and birth dates of all the dependents to be insured. Indicate ‘son’ or ‘daughter’ for each child.

**4. Certification and Authorization** - Please read, sign, and date.