

BOSTON COLLEGE Supplemental Employee Life Insurance AETNA LIFE INSURANCE CO.

Enrollment Form	Group Policy No. 877075
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1. Employee Information			
Name	(first middle last)	Eagle ID	
(print) _____		_____ - _____	
Home Address	Telephone Numbers	Date of Hire	Date of Birth
_____	Campus Ext. _____	_____	_____
_____	Home# () _____ - _____	Male _____	Female _____

2. Request for Supplemental Life Insurance [IMPORTANT – Read Instructions on Reverse]		(For Benefits Use) Effective Date
A. Amount Already in Effect, if any: (i.e., from prior enrollment)	\$ _____	A. _____
B. Guaranteed Issue Amount requested: (For new employees and Open Enrollment only; may not exceed 1 times annual salary)	\$ _____	B. _____
C. Additional Amount requested: (Health Statement required)	\$ _____	C. _____
D. TOTAL AMOUNT REQUESTED (A+B+C): (May not exceed the lesser of 4 times annual salary or \$500,000. Health Statement required for any amount over \$250,000)	\$ _____	D. _____

3a. Primary Beneficiary(ies):	Date of Birth	Relationship
3b. Contingent Beneficiary(ies):	Date of Birth	Relationship

[If there is more than one beneficiary in a class, they will share the death benefits equally, unless otherwise noted. Contingent Beneficiary(ies) will only receive proceeds if all Primary Beneficiaries have predeceased the Insured. I reserve the right to change this designation at any time. If all beneficiaries predecease me, benefits will be payable to my estate.]

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 is subject to my being actively at work on that date. 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 eligibility for coverage 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 This authorization applies to the Plan until rescinded by me in writing.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 _____