RELIANCE STANDARD
Life Insurance Company
a DELPHI company

ILLINOIS COMMUNITY COLLEGE CONSORTIUM

Term Life and Accidental Death & Dismemberment Insurance Enrollment Form

FOR EMPLOYEE TO COMPLETE College Name: Sauk Valley Community College

	Basic Life	OptLife	Basic AD&D	Opt AD&D
Policy Nos	647129,	647139,	647211,	647212

EMPLOYEE NAME *(last name, first, middle initial)*	EMPLOYER NAME SAUK VALLEY COLLEGE		
SOCIAL SECURITY NUMBER	DATE OF BIRTH	ANNUAL EARNINGS	7 X ANNAUL SALARY
EMPLOYEE ADDRESS *(street, city, state, zip code)*			
SEX ☐ *Male* ☐ *Female*	DATE OF EMPLOYMENT	HOURS WORKED PER WEEK	OCCUPATION

COVERAGE ELECTIONS & AMOUNT OF COVERAGE SELECTED:

EMPLOYER PROVIDED BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE (GL647129) (VAR647211):

YOU: $______________ YOUR SPOUSE: $______________ EACH CHILD (LIFE ONLY): $______________

OPTIONAL LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE: (PURCHASED IN INCREMENTS OF $10,000) (GL647139) (VAR647212)

YOU: $______________
(not to exceed 7 times earnings)

YOUR SPOUSE: $______________
(not to exceed employee amount)

EACH CHILD (LIFE ONLY) : $______________
(not to exceed employee amount) (benefit must be elected in $2,500 increments to a maximum of $10,000)

NOTE: If you have chosen coverage over the Guarantee Issue amount of $150,000 for you, $100,000 for your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting approval and will become effective the date Reliance Standard approves the Evidence of Insurability Application. If you DO NOT APPLY FOR coverage for you or your dependent(s) during your initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage.

Spouse Information *(complete only if spouse coverage is selected)*

NAME:	SOCIAL SECURITY #:	DATE OF BIRTH:

Dependent Child Information *(complete only if child coverage is selected)(if you have more than 2 children, please use separate piece of paper)*

NAME:	SOCIAL SECURITY #:	DATE OF BIRTH:
NAME:	SOCIAL SECURITY #:	DATE OF BIRTH:

Beneficiary Information

NAME *(last name, first, middle initial)*:	RELATION TO YOU:	BENEFIT %:
IF THE BENEFICIARY(IES) NAMED ABOVE ARE NOT LIVING, THEN PAY:		

REQUEST FOR SIGNATURE: Please read the back of this form carefully before signing below.

CERTIFICATION: 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 have read and understand the INFORMATION ABOUT DELAYED EFFECTIVE DATES on the reverse side of this enrollment form. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

______________________________ __ __/__ __/__ __ __ __ ______________ ______________
Employee Signature *Date* *Work Phone* *Home Phone*