Enrollment/Change Request

Group Universal Life - Aetna Life Insurance Company

Please complete the entire form and return to:
College Benefits Group
PO Box 522
Storrs, CT 06268
Telephone: (860) 429-9000
Fax: (860) 429-9513

Control Number						Suffix			Account		
4	7	3	0	7	2	0	1	0	0	0	1

A. Enrollment/Change Information

Participating Employer	Check One:	Requested Effective Date
University of Connecticut	☐ Enrollment ☐ Family Status ☐ Change	

B. Identification - Please Print All Information

Employee	Spouse/Domestic Partner - Only complete if applying for coverage.
Name (Last, First, Middle Initial)	Name (Last, First, Middle Initial)
Home Address (Number and Street, City, State, ZIP Code)	Home Address (Number and Street, City, State, ZIP Code)
Telephone Numbers Home ( ) Work ( )	Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___
Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ Gender ☐ M ☐ F	Gender ☐ M ☐ F
Employee Number ___ ___ ___ ___ ___ ___ Birthdate (MM-DD-YYYY) Date of Hire (MM-DD-YYYY)	Birthdate (MM-DD-YYYY)

C. Employee and/or Spouse/Domestic Partner Coverage

Life Insurance - Employee	Life Insurance - Spouse/Domestic Partner
1. Indicate action to be taken. Coverage: ☐ Add ☐ Change ☐ Cancel	1. Indicate action to be taken. Coverage: ☐ Add ☐ Change ☐ Cancel
a. Employee Annual Earnings $ ________	a. Employee Annual Earnings $ ________
b. Total Coverage Desired ($10,000 Increments) = ________	b. Total Coverage Desired ($10,000 Increments) = ________
2. Accidental Death Coverage Coverage: ☐ Add ☐ Cancel	2. Accidental Death Coverage Coverage: ☐ Add ☐ Cancel
3. I elect the Automatic Increase Option ☐	3. I elect the Automatic Increase Option ☐
Accumulation Fund - Employee	**Accumulation Fund - Spouse/Domestic Partner**
4. Do you want to participate in the Accumulation Fund? ☐ Yes ☐ No	4. Do you want to participate in the Accumulation Fund? ☐ Yes ☐ No
5. Check appropriate action, if any. ☐ Add New Fund ☐ Change Existing Contribution ☐ Cancel Fund	5. Check appropriate action, if any. ☐ Add New Fund ☐ Change Existing Contribution ☐ Cancel Fund
4. Enter your desired bi-weekly contribution, if any. $ ________ per pay period	4. Enter your desired bi-weekly contribution, if any. $ ________ per pay period

D. Child Coverage (Refer to Instructions for Amounts Available)

Life insurance for each eligible child*, regardless of number of children.

☐ Add Coverage $ 10,000

☐ Cancel Coverage

☐ Convert Coverage - Is this the last eligible child? ☐ Yes ☐ No

*When your last eligible child reaches the limiting age, it is your responsibility to cancel child coverage and premium deductions. A child may qualify for coverage beyond the limiting age if certain conditions exist.

E. Employee Status (For Existing Enrollees)

Please tell us if anything has changed since you last enrolled. (Give all dates as MM-DD-YYYY.):

☐ Divorce

☐ Employment Terminated - Give Date ___ ___ - ___ ___ - ___ ___ ___ ___

☐ Marriage - Give Date ___ ___ - ___ ___ - ___ ___ ___ ___

☐ Retired - Give Date ___ ___ - ___ ___ - ___ ___ ___ ___

☐ Unpaid Leave of Absence - Give Expected Return to Work Date ___ ___ - ___ ___ - ___ ___ ___ ___

☐ Name (legally changed from) ________

☐ Address (old address) ________

☐ I am terminating my employment and wish to be billed at my house.

Please be sure to make a photocopy for your records.

Tobacco/No AD&D/Yes

F. Beneficiary Information

☐ Check here if additional beneficiaries are listed on page 3 of this form.

Employee's Beneficiary:	**Primary** (Full Name) ______ Relationship ______ Social Security Number ______ Date of Birth ______ Percentage ______ Address ______ City ______ State ___ ZIP Code ______ Telephone Number ______
	1st Contingent (Full Name) ______ Relationship ______ Social Security Number ______ Date of Birth ______ Percentage ______ Address ______ City ______ State ___ ZIP Code ______ Telephone Number ______
	2nd Contingent (Full Name) ______ Relationship ______ Social Security Number ______ Date of Birth ______ Percentage ______ Address ______ City ______ State ___ ZIP Code ______ Telephone Number ______
Spouse/Domestic Partner's Beneficiary:	**Primary** (Full Name) ______ Relationship ______ Social Security Number ______ Date of Birth ______ Percentage ______ Address ______ City ______ State ___ ZIP Code ______ Telephone Number ______
	Contingent (Full Name) ______ Relationship ______ Social Security Number ______ Date of Birth ______ Percentage ______ Address ______ City ______ State ___ ZIP Code ______ Telephone Number ______

G. Medical Information (If either of the following questions is answered "Yes," please complete an Evidence of Good Health form.)

Employee		Spouse/Domestic Partner		In the past 5 years, have you had or sought medical attention for any of the following illnesses/conditions/impairments:
Yes	No	Yes	No	
☐	☐	☐	☐	1. Chest pain, high blood pressure, stroke, or disease of the heart, blood, or lungs; cancer; diabetes; mental illness; convulsions, or any disease of the brain, nervous system or lymph glands?
☐	☐	☐	☐	2. AIDS, AIDS related disorders or any immune deficiency disorder; alcohol or drug abuse; or any disease of the stomach, intestines, liver or kidneys?

H. Certification and Authorization

Employee E-mail Address

My signature below signifies my agreement with the **Certification and Authorization** below.

The Employee must sign at all times. The Spouse/Domestic Partner must sign when spouse/domestic partner coverage is requested.

Employee or Authorized Person Signature	Date Signed	Spouse/Domestic Partner or Authorized Person Signature	Date Signed
X		X	

Certification and Authorization

I certify that all of the 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 of the terms of the Plan of Insurance contained in the group policy and summarized in the announcement materials provided me and 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, in the event I fail to sign this form within **60 days** of the effective date of eligibility or that for any reason Aetna does not receive notice of the Enrollment/Change Request within a reasonable time following the date I was eligible to enroll or change my coverage, my and my dependents' eligibility may be affected.

I request my employer to arrange for the issuance of Group Universal Life Coverage for which I am or may become eligible and authorize deductions of the required contributions from my earnings. I understand that, in the event I fail to sign this form within **60 days** of the effective date of eligibility or that for any reason Aetna does not receive notice of the Enrollment/Change Request within a reasonable time following the date I was eligible to enroll or change my coverage, my and my dependents' eligibility may be affected. I request my employer to arrange for the issuance of Group Universal Life Coverage for which I am or may become eligible and authorize deductions of the required contributions from my earnings.

Privacy Notice

In evaluating your insurability, we rely primarily on the health information you furnish to us in this statement.

Disclosure of Information

All of this information will be treated as confidential and will not be disclosed to others without your authorization, except to the extent necessary for the conduct of our business and not contrary to any law. In addition, information may be furnished to regulators of our business and to others as may be required by law, and to law enforcement authorities when necessary to prevent or prosecute fraud or other illegal activities.

Your Right of Access & Correction

In general, you have a right to learn the nature and substance of any information in our files about you. You also have a right of access to such files (except information which relates to a claim or a civil or criminal proceeding) and to request correction, amendment or deletion of recorded personal information in states which provide such right and grant immunity to insurers providing such access. We may elect, however, to disclose details of any medical information you request to your (attending) physician. If you wish to exercise this right or if you wish to have a more detailed explanation of our information practices, please contact:

Aetna Life Insurance Company, Medical Underwriting Department, 151 Farmington Avenue, Hartford, CT 06156-2975

Please be sure to make a photocopy for your records.

Misrepresentation

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Attention Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention California Residents**: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Attention Colorado Residents**: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Attention Florida Residents**: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree. **Attention Kansas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Kentucky Residents:** Any person who knowingly and with intent to **defraud** any insurance company or other person files a statement of claim containing any materially **false** information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a **crime**. **Attention Louisiana Residents**: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison. **Attention Maine and Tennessee Residents**: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits. **Attention Maryland Residents**: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Attention Missouri Residents:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, denial of insurance and civil damages, as determined by a court of law. Any person who knowingly and with intent to injure, defraud or deceive an insurance company may be guilty of fraud as determined by a court of law. **Attention New Jersey Residents**: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **Attention New York Residents, the following statement applies only to your AD&D and Disability coverage**: 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 conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. **Attention North Carolina Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties. **Attention Ohio Residents**: Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **Attention Oklahoma Residents**: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **Attention Oregon Residents**: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law. **Attention Pennsylvania Residents**: 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 conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **Attention Puerto Rico Residents**: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years. **Attention Texas Residents:** Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any intentional misrepresentation of material fact or conceals, for the purpose of misleading, information concerning any fact material thereto may commit a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Vermont Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **Attention Virginia Residents**: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties. **Attention Washington Residents**: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Additional Space for Beneficiary Information

Employee's Beneficiary:	**Primary** (Full Name) ____ Relationship ____ Social Security Number ____ Date of Birth ____ Percentage ____ Address ____ City ____ State ____ ZIP Code ____ Telephone Number ____
	1st Contingent (Full Name) ____ Relationship ____ Social Security Number ____ Date of Birth ____ Percentage ____ Address ____ City ____ State ____ ZIP Code ____ Telephone Number ____
	2nd Contingent (Full Name) ____ Relationship ____ Social Security Number ____ Date of Birth ____ Percentage ____ Address ____ City ____ State ____ ZIP Code ____ Telephone Number ____
Spouse/Domestic Partner's Beneficiary:	**Primary** (Full Name) ____ Relationship ____ Social Security Number ____ Date of Birth ____ Percentage ____ Address ____ City ____ State ____ ZIP Code ____ Telephone Number ____
	Contingent (Full Name) ____ Relationship ____ Social Security Number ____ Date of Birth ____ Percentage ____ Address ____ City ____ State ____ ZIP Code ____ Telephone Number ____

Please be sure to make a photocopy for your records.