



**The University of Mississippi**  
Policy #111686-001

Name:	Social Security #:
Date of Hire:	Date of Birth:

Circle the option you choose to enroll in, enter your Amount of Coverage by multiplying 1X, 2X, 3X, 4X, 5X, or 6X by your base salary, enter the Monthly Cost by multiplying your Amount of Coverage times the Rate (See Plan Highlight Sheets) In the space provided. This form must be returned to your employer prior to the end of the enrollment period.

You have the option to purchase term life and accidental death and dismemberment coverage in increments of 1X, 2X, 3X, 4X, 5X or 6X your annual base salary rounded up to the nearest thousand. The total Supplemental Life coverage cannot exceed \$600,000.

You may be required to complete a medical evidence of insurability form to request or increase coverage. See Plan Highlights.

Supplemental Term Employee Life and AD&D	Amount of Coverage	Monthly Cost (AMT Coverage X Rate) (see Plan Highlights for rates)
A) 1X Annual Base Salary		
B) 2X Annual Base Salary		
C) 3X Annual Base Salary		
D) 4X Annual Base Salary		
E) 5X Annual Base Salary		
F) 6X Annual Base Salary		
G) No Coverage	0	0.00

Your monthly cost \$ \_\_\_\_\_

Supplemental Term Spouse Life and AD&D  Amount of Coverage	Monthly Cost (AMT Coverage X Rate) (see Plan Highlights for rates)
A) \$25,000	
B) \$50,000	
C) \$75,000	
D) \$100,000	
E) No Coverage	\$0.00

Your monthly cost \$ \_\_\_\_\_

**Child & AD&D:** You must purchase Employee Supplemental Life and AD&D to purchase Child Life and AD&D. The cost illustrated is to cover all of your eligible children

A) \$5,000 to age 6 months \$10,000 age 6 months to age 19, or 25 if full time student	Monthly Cost \$2.08
B) No Coverage	\$0.00

Your monthly cost \$ \_\_\_\_\_

<b>Total Amount of ALL Elections</b> .....	<b>= \$</b> _____
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**Beneficiary Information**

PRIMARY DESIGNATION <input type="checkbox"/> My beneficiaries are:			
Full Name	SSN	Relationship to You	% of Benefit

**I. LIMITATIONS AND EXCLUSIONS**

**Delayed Effective Date**

*Employee:*  
Insurance will be delayed for Employees not actively at work until the first of the month following the date they return to work. Regularly scheduled vacation time is considered active employment.

*Dependent:*  
Coverage for totally disabled dependents will be delayed until the first of the month following the date the individual is no longer totally disable.

**Exclusion for Suicide**

*Where the cause of death is suicide:*

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date of insurance.
2. No increased or additional insurance amount will be payable for a loss occurring within 24 months after the day such increased or additional coverage is effective.

**AD&D Benefit Exclusion**

**AD&D Benefits will not be paid for losses if the cause is related to the following:**

- Disease of the body; diagnostic, medical or surgical treatment; or mental disorders as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders.
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane, or self-inflicted injury while sane, or self-inflicted injury while insane.
- War, declared or undeclared, or any act of war.
- Active participation in a riot.
- Attempt to commit or commission of a crime under state or federal law.
- The voluntary use of any prescription or non-prescription drug, poison, fume or any other chemical substance unless use is according to the prescription or direction of the individual's doctor.
- Operating any motorized vehicle while intoxicated. "Intoxicated" means that the individual's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state where the accident occurred.

**II. CERTIFICATION**

I certify that the information supplied by me on this form is true and correct to the best of my knowledge and belief. I have read and understand the INFORMATION ABOUT DELAYED EFFECTIVE DATES and EXCLUSIONS above. I have also read and understand the information in the Enrollment Kit, including all statements regarding exclusions. If electing to participate in any of the benefit plans mentioned above, I authorize the required payroll deductions. I understand that my payroll deduction amount will change if my coverage or costs change. I understand that if I cancel/decline participation, I may join the Plan at a specified later date; however, I will be required to provide evidence of insurability at my own expense, and the insurance company may refuse my request. In the event of any variations between this form and the Plan document, the terms of the Plan document will prevail.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

<b>For Office Use Only</b>	
<b>Monthly Costs Prior to Approval of Amounts Over Guarantee Issue</b>	
Employee Monthly Cost: Amount of Coverage/1000*Rate	\$ _____
Spouse Monthly Cost: Amount of Coverage/1000*Rate	\$ _____