Kenai Peninsula Borough School District
Standard Life Insurance Enrollment Form Policy# 757518

Name (L*ast, First, Middle Initial*): _____

Address: _____ **City,State,Zip:** _____

Date of Birth: _____ **Sex:** ☐ **Male or** ☐ **Female**

Marital Status: ☐ **Single** ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Legally Separated** **SPOUSE EMPLOYED BY KPBSD?** ☐ **Yes or** ☐ **No**

Employment Date: _____ **Social Security #** _____

Job Title: _____ **Class:** _____ **Phone#** _____

☐ **New Coverage** ☐ **Name Change:**_____ ☐ **Beneficiary Change** ☐ **Other Change**_____

PRIMARY BENEFICIARY(IES)

Beneficiary's Name & Address	Social Security Number	Relationship	Date of Birth	Percentage: Must total 100%
Name: Address: Phone:				
Name: Address: Phone:				
Name: Address: Phone:				

CONTINGENT BENEFICIARY(IES) – ***will only receive benefit if there are no surviving primary beneficiaries***

Beneficiary's Name & Address	Social Security Number	Relationship	Date of Birth	Percentage: Must total 100%
Name: Address: Phone:				
Name: Address: Phone:				
Name: Address: Phone:				

BASIC COVERAGE PAID BY SCHOOL DISTRICT (No cost to employee)

X **Basic Life, Accidental Death and Dismemberment –** *employee is covered person; coverage is one times annual salary rounded up to the next thousand. Class 4 maximum coverage of $250,000. Class 3 maximum coverage of $350,000. Coverage reduced by 35% at age 75; 50% at age 80*

_____ **Additional Spouse Life –** *only available if married and Spouse is NOT school district employee; coverage is flat $10,000*

OPTIONAL VOLUNTARY COVERAGE PAID BY EMPLOYEE – *Must elect to receive coverage*

_____ **Double Life** (Additional Voluntary Life for employee only) **–** *coverage is additional one times annual salary rounded up to the next thousand. Maximum benefit of $150,000 unless employee submits Evidence of Insurability Form. Cost is $0.155 per $1,000. Coverage reduced by 35% at age 75; 50% at age 80*

_____ ***Spouse –** coverage is flat $2,000 for your Spouse. $0 cost. *This benefit only applies if Double Life is also elected.*

_____ ***Children –** coverage is flat $2,000 for each eligible child. $0 cost. *This benefit only applies if Double Life is also elected. Covers dependent children ages 1 day to 19 years or 23 if a full-time student.*

I hereby (A) request the indicated coverage for which I am or may become eligible under the policies issued by Standard Life Insurance Company; (B) authorize the required deduction, if any, from my earnings; (C) designate the beneficiary(ies) named on this form to receive the benefits, if any, payable in the event of my death; and (D) certify that any and all information disclosed on this enrollment request is accurate and that I became an employee of the named employer in the capacity and on the date stated above and do presently work for that employer. *Please refer to the Group Life Insurance Policy for eligibility and a complete list of terms and benefits.*

DATE _____ SIGNATURE _____

REFUSAL OF COVERAGE: If you are refusing coverage, please state the reason for refusal:

Date: **Signature:**