Nationwide
On Your Side®

Nationwide Life Insurance Company	Commonwealth of Kentucky
Home Office: Columbus, Ohio	Employee Group Life Insurance Program
	Group Insurance Contract: BE 0002

SSN	Location Name (Specify name or Agency, School Board or Health Dept.)		
Name (Last, First, MI)	Location Number	Birth date	
Address (Street Name/Number)	Annual Salary	Hire Date	Gender ☐Male ☐Female
(City, County, State, Zip)	Work Number	Home Number	

☐ Termination: Date Employment Ends _____ Date Life Insurance Terminates _____

Reason: ☐ Resigned ☐ Retired ☐LWOP ☐ Death ☐ Military Leave ☐ Other

☐ Reinstate Coverage: Date Returned to Work _____ Date Insurance Effective _____

Reason: ☐ Rehired ☐ FMLA ☐ LWOP ☐ Death ☐ Military Leave ☐ Other

☐ Transfer or Summer Transfer (To be completed by the **NEW** company)

Prior Company Number	New Company Number
Last Day Worked at Prior Company	Date Hired at New Company
Coverage End Date at Prior Company	Coverage Begin Date at New Company

A. Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Eligible employees are insured at no cost to the employee for Basic Life and AD&D Insurance

All Eligible Employees $20,000 Cost: (employer paid)

B. Optional Life and Accidental Death and Dismemberment (AD&D) Insurance (Select One Plan)

I wish to _____enroll* in, _____change* to, or _____ terminate* the optional insurance plan checked below: **(Select one plan only)**

Monthly Contribution

Age Band	Rate per $1,000
Under 40	**$0.24**
40-59	$0.60
60 and over	**$0.98**

☐ Plan 1 $5,000	☐ **Plan 3 (NEW) $25,000**	☐ Plan 5 1X Annual Salary**
☐ Plan 2 $10,000	☐**Plan 4 (NEW) $50,000**	☐ Plan 6 2X Annual Salary**

***Evidence of insurability may be required depending on the circumstances and/or for insurance over $150, 000.**

****Under Plans 5 and 6, insurance amounts will be rounded to the nearest multiple of $1,000. Amounts of insurance will increase with an earnings change.**

C. Dependent Life Insurance (Select One Plan)

Please ___ enroll* my dependents in, ___ change*my present plan to, or _____ terminate* the plan checked below: **(Select one plan only)**

	☐ Plan A	☐ Plan B	☐ Plan C	☐ Plan D	☐ Plan E
Spouse**	$10,000	$5,000	$5,000	$10,000	---
Dependent Children to 6 mos	$2,500	$1,500	---	---	$2,500
Dependent Children 6 mos to 18 yrs***	$5,000	$3,000	---	---	$5,000
Monthly Contribution	$11.46	$6.20	$2.62	$9.14	$3.78

***Evidence of insurability may be required depending on circumstances**

****Spouse means a person to whom you are legally married**

***** 18 and older if attending an educational institution and relying on the employee for financial support**

D. Waiver of Optional Life and Dependents Coverage

☐ I certify that I have been given the opportunity to enroll myself and my eligible dependents in the above coverage. I have declined the Optional and/or Dependents Life coverage and understand that it will be necessary for me and my dependents to furnish evidence of insurability if I desire any of the above coverage in the future (other than during an open enrollment period or other exception detailed in the certificate booklet).

E. Fraud Warning: Any Person who knowingly and with intent to injure, defraud, or deceive an insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss of benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

F. Employee Signature and Date (Required)

I, the undersigned, certify that I have read the completed enrollment/change/termination form and agree that all answers in this form are true and complete to the best of my knowledge and belief. I hereby authorize my employer to deduct from my paycheck or earnings the amount required to cover my share of the coverage I have selected.

Employee Signature _____ **Date** _____

IC/HRG Signature_____ **Date**_____

Send Copy to your Insurance Coordinato