University of California, Los Angeles

MEDICAL FACULTY GROUP PRACTICE PLAN ENROLLMENT FORM

Supplementary Insurance on the "Y" or "Delta" Income

DEPARTMENT:_____

TO BE COMPLETED BY DEPARTMENT

This enrollment is: ☐ Original ☐ Revision ☐ Cancellation Effective Date: _____/_____/_____ MM DD YYYY

If Revision, check item (s) to be changed: ☐ Beneficiary ☐ Earnings ☐ Dependent Status

1. Annual Supplement: _____ 2. Monthly Supplement: _____

TO BE COMPLETED BY FACULTY MEMBER ELIGIBLE FOR SUPPLEMENTARY LIFE AND AD&D

Your Name: _____ Social Security No.: _____
(Print) Last, First, MI

Employee No.: _____ Your Birthdate: _____/_____/_____ Sex: ☐ Male ☐ Female
MM DD YYYY

BENEFICIARY:

Name: _____ _____
Last, First, MI Relationship

Address if different from Faculty Member: _____

_____

Additional Beneficiaries: (Full Name, Relationship and Address): _____

_____

ADDITIONAL INFORMATION TO BE COMPLETED BY FACULTY MEMBER WHO IS MARRIED

Spouse's Name: _____ Birthdate: _____/_____/_____
Last, First, MI MM DD YYYY

Date of Marriage: _____/_____/_____
MM DD YYYY

Youngest Child's Name: _____ Birthdate: _____/_____/_____
Last, First, MI MM DD YYYY

I hereby (1) request that coverage for which I am eligible under the above policy issued by The Hartford Life & Accident Insurance Company; (2) designate the beneficiary named on this form to receive the benefits, if any, payable in the event of my death; and (3) certify that the above information is correct.

Signature: _____ Date Signed: _____/_____/_____
MM DD YYYY

A. LIFE INSURANCE AND ACCIDENTAL DEATH, DISMEMBERMENT AND LOSS OF SIGHT BENEFIT

3. Annual Supplement Rounded to next highest $1,000.00: _____ X $.000155 = _____
Monthly Premium

B SURVIVOR INCOME BENEFIT*

Married: ☐ Yes ☐ No**

4. Monthly Supplement: _____ X $.00774 = _____
Monthly Premium

*If less than 24 months, do not complete 4.
**Not necessary to complete 4.

_____
Total Monthly Premium

Approval:
Department: _____ Phone: _____ Date: _____/_____/_____
Signature

Rev 2/11/08