



Mark all boxes and complete all sections that apply. Return completed form to Human Resources.

APPLICANT	Your Name (Last, First, Middle)		Please Choose One <input type="checkbox"/> Town / <input type="checkbox"/> School		Group Name Town of Westford	
	Address		City		State	Zip
	Social Security #		Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation
INSURANCE	<p><i>Check with your Human Resources/Benefits Department about coverage options available to you and Evidence of Insurability requirements.</i></p>					
	<p>Life Insurance</p> <p><input type="checkbox"/> Town \$10K Basic Life and AD&D</p> <p><input type="checkbox"/> Additional Life/AD&D Increments of \$10,000 to \$250,000</p> <p>Amount Requested: \$ _____ <i>*Amount cannot exceed 5 times annual earnings</i></p>			<p>Dependent Life Insurance (employee paid)</p> <p><input type="checkbox"/> Spouse Life Increments of \$5,000 to \$150,000</p> <p><input type="checkbox"/> Child Life Increments of \$1,000 to \$10,000</p> <p>Amount Requested: \$ _____ Amount Requested: \$ _____</p> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><i>*Employee must be enrolled in Additional Life to elect Dependent Life coverage.</i></p> </div>		
	<p>Disability Insurance (employee paid) (60% of base salary)</p> <p><input type="checkbox"/> Short Term Disability</p> <p><i>Premium Amount:</i> \$ _____</p> <p><input type="checkbox"/> Long Term Disability</p> <p><i>Premium Amount:</i> \$ _____</p>			<p>Waive*/ Decline Coverage Please check off coverage(s) <u>declined</u>:</p> <p><input type="checkbox"/> Life Insurance/AD&D – Town \$10K: Waive/ Decline Coverage</p> <p><input type="checkbox"/> Life Insurance/AD&D- Supplemental: Waive/ Decline Coverage</p> <p><input type="checkbox"/> STD Insurance- Waive/ Decline Coverage</p> <p><input type="checkbox"/> LTD Insurance- Waive/ Decline Coverage</p>		
	<p><i>This designation applies to Life, AD&D and Additional Life Insurance available through your Employer, if any. Designations are NOT valid unless signed, dated, and delivered to your Employer during your lifetime.</i></p>					
BENEFICIARY	Primary- Full Name		Address		Social Security #	
	Relationship				% Benefit	
BENEFICIARY	Contingent- Fill Name		Address		Social Security #	
	Relationship				% Benefit	
CHANGE	<p><i>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</i></p> <p><input type="checkbox"/> Beneficiary Change <input type="checkbox"/> Other _____</p>					
	<p><i>I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction will change if my coverage or costs change.</i></p>					
SIGNATURE	Member/Employee Signature Required					Date (Mo/Day/YR)
Human Resources/Benefits Department- Complete this section. Retain form for your records						
Policy # 162241		Date of Hire	Hours Worked Per Week	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		