Supplemental Life Insurance Enrollment/Change Coverage Form

HR-BEN-058

Section 1 - Information and Instructions

The purpose of this form is to enroll or change coverage in the Supplemental Life Insurance program.

It is important to complete all sections of the form. If any relevant information should change, please resubmit this request form, highlighting the changes.

Please fax a signed copy of the form to 212-852-8700 or e-mail a signed copy of the form to bscservice@mtabsc.org.

If you have any questions, please contact MTA Business Service Center (BSC) at 646-376-0123 or bscservice@mtabsc.org.

Section 2 - Employee Information

Print Name	Last		First		M.I. Suffix	BSC ID
Agency/Dept. (check one)	☐ BSC	☐ B&T	☐ CC	☐ HQ	☐ Police	Department
	☐ SIR	☐ LIRR	☐ MNR	☐ MTA Bus	☐ NYCT	
					☐ MABSTOA	
Street Address						
City					State	Zip Code
Phone (H)		Phone (W)				Email
Date of Birth	Marital Status (check one box) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed					
Date of Hire	Payroll I.D. Number					

Section 3 – Enrollment or Change in Coverage

The option you elect will be a multiple of your annual base salary, rounded to the next higher $1,000 (if not already a multiple of $1,000). Amounts exceeding three times annual base salary or $200,000 (whichever is less) will require completion of an Employee Statement of Health Form, which must be processed and approved by the carrier. Additionally, if your elected amount is greater than $750,000, completion of a full statement of health form will be required, which must be processed and approved by the carrier. If at a later date you decide you would like to increase coverage, you may be required to provide medical evidence of good health satisfactory to the insurance carrier. The increase in coverage would not be effective until the carrier approves your application. ***Note: For represented employees, coverage amount is dependent on your Collective Bargaining Agreement.***

I hereby elect the following coverage (check one box only)

☐ One times annual base salary	☐ Four times annual base salary
☐ Two times annual base salary	☐ Five times annual base salary
☐ Three times annual base salary	

Reason for change in coverage:

Section 4 - Beneficiary Information

You may designate more than one person as your primary and/or contingent beneficiary. Use a separate sheet if more space is needed.

☐ Check this box if you are changing or revoking your previous beneficiary designation

A) Primary Beneficiary(ies) In the column entitled "%" indicate the percent of benefits for beneficiary)

Full Name	%	Date of Birth	Social Security #	Relationship to Employee	Home Address (street, city, state, zip code)

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Section 4 - Beneficiary Information Continued

B) Contingent Beneficiary (ies): In the unfortunate circumstance something happens to the Primary Beneficiary, the contingent beneficiary will receive the benefits. (In the column entitled "%" indicate the percent of benefits for beneficiary)

Full Name	%	Date of Birth	Social Security #	Relationship to Employee	Home Address (street, city, state, zip code)

Section 5 – Authorization

I hereby request Supplemental Life Insurance and authorize my employer to make deductions from my earnings of the required contributions to apply toward the premiums for the insurance provided for in the policy issued to my employer by the carrier. Further, I hereby represent and agree that all answers and statements in this request are full, complete and true to the best of my knowledge and understand that said answers and statements form the basis upon which insurance will be made effective.

Employee Signature	Date

Section 6 – Waiver of Coverage

I hereby elect to waive coverage. I understand that if, at a later date, I decide I would like to participate in the plan, I may be required to provide medical evidence of good health satisfactory to the carrier. Further, I understand that my participation in the plan would not be effective until approval is received from the carrier.

Employee Signature	Date