

# Accidental Death and Dismemberment Group Insurance

## Application

University of Wisconsin Hospital and Clinics

Underwritten by: Zurich Insurance Co., Policy No. GTU 25 84-087

Employee Name: (Last, First, MI) \_\_\_\_\_

Employee SSN: \_\_\_\_\_

Employee UWHC ID: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Reason for Submitting Form:

- Elect Coverage
- Cancel Coverage
- Change in Coverage
- Change of Beneficiary
- Other: \_\_\_\_\_

Coverage Elected:

Employee Only      Benefit Amount Selected: \_\_\_\_\_      Monthly Premium: \_\_\_\_\_

Family      Benefit Amount Selected: \_\_\_\_\_      Monthly Premium: \_\_\_\_\_

Spouse Name: (Last, First, MI): \_\_\_\_\_

Spouse SSN: \_\_\_\_\_

Employee Beneficiary Name: (Last, First, MI): \_\_\_\_\_

Employee Beneficiary SSN: \_\_\_\_\_

Relationship: \_\_\_\_\_

Note! The beneficiary for Spouse and Dependent Children is the Employee named above.

Employee Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Office Use Only	
Date Received:	Date Entered:
Human Resources Representative:	