ENROLLMENT FORM FOR GROUP ACCIDENT INSURANCE
FOR THE EMPLOYEES OF U.W. HOSPITAL & CLINICS

Underwritten by Zurich American Insurance Company
Policy Number: **GTU 2584087**

Reason for Submitting Form:

☐ Elect coverage ☐ Change Coverage ☐ Cancel Coverage ☐ Beneficiary Change
☐ Other:

Employee Information:			
Last Name:	First Name:	M.I.:	Occupation:
Social Security Number:		Sex:	Date of Birth:
Spouse/Domestic Partner Name:		Spouse/Domestic Partner Occupation:	
Beneficiary Designation & Relationship:		The beneficiary for **Spouse/Domestic Partner** and **Dependent Child(ren)** is the employee named on the enrollment form.	

Coverage Information:		
Plan (check one): ➔	☐ Plan I – Employee Only	☐ Plan II – Family Coverage
Coverage Amount (check one):	Employee Plan Monthly Premium	Family Plan Monthly Premium
☐ $50,000	$1.50	$2.25
☐ $100,000	$3.00	$4.50
☐ $150,000	$4.50	$6.75
☐ $200,000	$6.00	$9.00
☐ $250,000*	$7.50	$11.25
☐ $300,000*	$9.00	$13.50
☐ $350,000*	$10.50	$15.75
☐ $400,000*	$12.00	$18.00
☐ $450,000*	$13.50	$20.25
☐ $500,000*	$15.00	$22.50

* Benefit amounts in excess of $250,000 may not exceed ten (10) times your base annual pay excluding overtime, bonuses, commissions and special compensation.

Signature Section:

☐ I elect the coverage above and authorize the monthly insurance premiums to be deducted from my earnings.
☐ I have been given the opportunity to apply for this insurance but I do not desire to participate at this time.
☐ I elect to cancel my coverage.

Your Signature:	Date:

For Employer Use Only:	
Date Received:	Effective date of coverage/change:
Assistant Initials:	PS Entry Date: