Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Commonwealth of Kentucky
Employee Group Life Insurance Program
Enrollment/Change/Termination Form
Group Insurance Contract: NP01002

2019 Plan Year

Application Type: ☐ New Hire ☐ Qualifying Event ☐ Open Enrollment		
Company Number	Company Name (Specify name or Agency, School Board or Health Dept.)	
Name (Last, First, MI)	SSN	Date of Birth
Address (Street Name/Number)	Hire Date	Gender
City, County, State, Zip	Work Telephone	Home Telephone

Termination	
Date Employment Ends:	Date Life Insurance Terminates:
Reason: ☐ Resigned ☐ Retired ☐ LWOP ☐ Death ☐ Military Leave ☐ Other_____	

Reinstatement	
Date Returned to Work:	Date Life Insurance Effective:
Reason: ☐ Resigned ☐ Retired ☐ LWOP ☐ Death ☐ Military Leave ☐ Other_____	

Transfer or Summer Transfer	
Prior Company Number:	New Company Number:
Last Day Worked at Prior Company:	Date Hired at New Company:
Coverage End Date at Prior Company:	Coverage Begin Date at New Company:

A. Basic Life and Accidental Death and Dismemberment (AD&D) Insurance

Eligible employees are insured at no cost to the employee for $20,000 Basic Life and AD&D Insurance. This insurance is employer paid.

B. Optional Life and Accidental Death and Dismemberment (AD&D) insurance (Select One Plan)

I wish to ☐ enroll*in, ☐ change*to, or ☐ terminate the optional insurance plan checked below:

	☐ Plan 1: $5,000	☐ Plan 2: $10,000	☐ Plan 3: $25,000	☐ Plan 4: $50,000	☐ Plan 5: 100,000	☐ Plan 6: 150,000
< Age 40	$1.10	$2.22	$5.52	$11.04	$22.08	$33.12
Age 40-59	$2.76	$5.52	$13.80	$27.60	$55.20	$82.80
60+	$4.52	$9.02	$22.54	$45.08	$90.16	$135.24

C. Dependent Life Insurance (Select One Plan)

I wish to ☐ enroll*my dependents in, ☐ change*to, or ☐ terminate the optional insurance plan checked below:

	☐ Plan A	☐ Plan B	☐ Plan C	☐ Plan D	☐ Plan E	☐ Plan F	☐ Plan G	☐ Plan H
Spouse**	$10,000	$5,000	$5,000	$10,000	-	$20,000	$20,000	-
Dependent Children to 6 mos	$2,500	$1,500	-	-	$2,500	$2,500	-	$2,500
Dependent Children 6 mos to 18 yrs ***	$5,000	$3,000	-	-	$5,000	10,000	-	$10,000
Monthly Contribution	$10.54	$5.70	$2.42	$8.42	$3.48	$21.08	$16.82	$6.96

* Evidence of insurability may be required depending on circumstance.

**Spouse means a person to whom you are legally married.

***18 and older if attending an educational institution and relying on the employee for financial support or incapacitated and proof received within 31 days of age limit.

D. Nationwide Life Insurance Company
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Waiver of Optional Life and Dependents Coverage

☐ I certify that I have been given the opportunity to enroll myself and my eligible dependents in the above coverage. I have declined the Optional and/or Dependents Life coverage and understand it will be necessary for me and my dependents to furnish evidence of insurability if I desire any of the above coverage in the future (other than during an open enrollment period or other exception detailed in the certificate booklet).

E. Fraud Warning

Any Person who knowingly and with intent to injure, defraud, or deceive an insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

F. Employee Signature and Date (Required)

I, the undersigned, certify that I have read the completed enrollment/change/termination form and agree that all answers in this form are true and complete to the best of my knowledge and belief. I hereby authorize my employer to deduct from my paycheck or earnings the amount required to cover my share of the coverage I have selected.

Employee Signature _____ Date _____

IC/HRG Signature _____ Date _____

IC/HRG Phone Number _____ Company #_____

Nationwide Life Insurance Company
Home Office: Columbus, Ohio

Nationwide is on your side

Nationwide Employee Benefits SM
Group Life and Accidental Death Designation of Beneficiary Form

Section 1: Insured Information (Please complete all appropriate boxes in ink, printing legibly.)

Group Name	Group Number
Commonwealth of Kentucky	**NP01002**
Company Name (Specify name or Agency, School Board or Health Dept.)	Company Number
Employee Name (First, Middle Initial, Last)	Social Security Number

Subject to the terms and conditions of the above referenced Group Number, I request that any sum becoming payable by reason of my death be payable to the following beneficiary (ies). It is my understanding that this designation shall operate so as to revoke all designations of beneficiary (ies) previously made by me under the Group Policy.

Employee Signature (Required)	Date (Required)

Note: Beneficiary designation is not valid unless this form and any separate accompanying sheets are signed and dated.

Section 2: Beneficiary Designation/Change (Please complete all appropriate boxes in ink, printing legibly. If you do not designate one or more beneficiaries, policy proceeds will be paid to your estate unless otherwise regulated by law.

Basic Life and AD&D

Primary Beneficiary Information (Allocation to all Primary Beneficiaries must equal 100%)

Beneficiary Name	Address (City, State, Zip)	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit

Contingent Beneficiary Information (Allocation to all Contingent Beneficiaries must equal 100%)

Beneficiary Name	Address (City, State, Zip)	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit

Optional Life and AD&D

Primary Beneficiary Information (Allocation to all Primary Beneficiaries must equal 100%)

Beneficiary Name	Address (City, State, Zip)	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit

Contingent Beneficiary Information (Allocation to all Contingent Beneficiaries must equal 100%)

Beneficiary Name	Address (City, State, Zip)	Relationship	Date of birth	SSN (XXX-XX-XXXX)	% of Benefit

Section 3: General Information

- If more room is needed to indicate additional primary or contingent beneficiaries, please attach a separate sheet and list the information indicated above for each beneficiary. Please sign and date all additional sheets as well as this original form.
- Your group life coverage is issued by Nationwide Life Insurance Company, One Nationwide Plaza, 4-06-101 Columbus, OH 43215. Please refer to the Certificate of Insurance and Insurance Contract for all plan details, including any exclusions, limitations and restrictions which may apply.

Submit your completed form to: Personnel Cabinet – Group Life Administration
501 High Street, Second Floor, Frankfort, Kentucky 40601