State Classified
Voluntary AD&D Insurance Enrollment & Change Form

Colorado State University

1. Employee Information: ***(Please Print)***

Last Name, First M.I.: _____ Employee ID#: _____

Birth Date: _____ Gender: ☐ Male ☐ Female Daytime Phone: (_____)_____

☐ Enrollment ☐ Increase ☐ Decrease ☐ Cancel ☐ Beneficiary Change

2. Policy: ☐ Employee ☐ Family* **Total Coverage Amount $**_____

*Eligible Family [Spouse or Domestic Partner/Dependent(s)] to cover: Birth Date Relationship

_____

_____

_____

3. Beneficiary Designation:

Name of Primary Beneficiary(ies) Birth Date Relationship

_____

_____

Name of Contingent Beneficiary(ies)

_____

_____

Benefits Use Only
Coverage Effective Date
Premium
$

I hereby apply for insurance under the group policy issued to my employer, subject to all terms, conditions and provisions of said policy. I authorize deductions from my earnings, until further notice, for this insurance.

Signature: _____ **Date:** _____

HRSD 01/2011