



2019 Life Insurance Enrollment and Change Form

Effective Date : _____

Employee Information:

_____	_____
Name (Please Print)	Social Security Number

Date of Birth	

Contact Information:

_____	_____	_____	_____
Street	City	ST	Zip
_____	_____		
Home Phone	Work Phone		

Life Insurance Primary Beneficiary:

Name	Relationship	Address	Percentage	Phone
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Life Insurance Contingent Beneficiary:

Name	Relationship	Address	Percentage	Phone
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

I certify that, to the best of my knowledge, that the information provided on this form is correct and complete. I understand that it is my responsibility to notify Truman State University within thirty-one (31) days of a change in family status.

_____	_____
Signature	Date