2024 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