2025 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 ______________________