



Nationwide Life Insurance Company
 Home Office: Columbus, Ohio

Commonwealth of Kentucky
 Employee Group Life Insurance Program
Open Enrollment Form
 Group Insurance Contract: BE 0002

OPEN ENROLLMENT -- SELECTIONS EFFECTIVE 1/1/2015

SSN		Location Name (Specify name or Agency, School Board or Health Dept.)			
Name (Last, First, MI)		Location Number		Birth date	
Address (Street Name/Number)		Annual Salary	Hire Date		Gender <input type="checkbox"/> Male <input type="checkbox"/> Female
(City, County, State, Zip)		Work Number		Home Number	

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

Eligible employees are insured at no cost to the employee for Basic Life and AD&D Insurance
 All Eligible Employees \$20,000 Cost: (employer paid)

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

I wish to _____ enroll* in, _____ change* to the optional insurance plan checked below: (Select one plan only)

Monthly Contribution

Age Band	Rate per \$1,000
Under 40	\$0.24
40-59	\$0.60
60 and over	\$0.98

<input type="checkbox"/> Plan 1 \$5,000	<input type="checkbox"/> Plan 3 (NEW) \$25,000	<input type="checkbox"/> Plan 5 1X Annual Salary**
<input type="checkbox"/> Plan 2 \$10,000	<input type="checkbox"/> Plan 4 (NEW) \$50,000	<input type="checkbox"/> Plan 6 2X Annual Salary**

*Evidence of insurability may be required depending on the circumstances and/or for insurance over \$150,000.

**Under Plans 5 and 6, insurance amounts will be rounded to the nearest multiple of \$1,000. Amounts of insurance will increase with an earnings change.

C. Dependent Life Insurance (Select One Plan)

Please _____ enroll* my dependents in, _____ change* my present plan to the plan checked below: (Select one plan only)

	<input type="checkbox"/> Plan A	<input type="checkbox"/> Plan B	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan D	<input type="checkbox"/> Plan E
Spouse**	\$10,000	\$5,000	\$5,000	\$10,000	---
Dependent Children to 6 mos	\$2,500	\$1,500	---	---	\$2,500
Dependent Children 6 mos to 18 yrs***	\$5,000	\$3,000	---	---	\$5,000
Monthly Contribution	\$11.46	\$6.20	\$2.62	\$9.14	\$3.78

*Evidence of insurability may be required depending on circumstances

** 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

D. 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, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss of benefit commits a 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.

E. 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 _____

Send Copy to your Insurance Coordinator