# VOLUNTARY LIFE FORM

MONTANA UNIFIED SCHOOL TRUST

***IF YOUR GROUP DOES NOT OFFER VOLUNTARY LIFE, PLEASE DISREGARD THIS PAGE.***

***This form must be returned to your Business Manager / Clerk. Do not submit directly to MUST.***
**CLERKS: After review please submit all forms to forms@ms-sf.org**

## 1

| School District Name: | Group No: | Effective Date: |
|---|---|---|

| First Name: | MI: | Last Name: | Last 4 of SSN: |
|---|---|---|---|

| Mailing Address: | City: | State: | Zip: |
|---|---|---|---|

| Phone Number: | Work Email: |
|---|---|

## 2 VOLUNTARY LIFE

**COVERAGE SELECTION:** Your non-medical group insurance program may not include all the benefits listed below. Ask your employer which benefits and pricing are available to you. If additional space is needed, please attach a second form and only complete those sections.

| **VOLUNTARY COVERAGE** (Check all that apply) Spouse includes Domestic Partner of Party to a Civil Union as defined in the Certificate | | (A) Add (C) Change (D) Delete | Total Amount of Coverage Desired | If (C) Changes, list Prior Coverage |
|---|---|---|---|---|
| ☐ Life / AD&D | Employee | X | | |
| ☐ Life / AD&D | Spouse | X | ☐ 5K ☐ 10K | |
| ☐ Life / AD&D | Children | (D) Delete | ☐ 5K ☐ 10K | |

| Spouse Last Name: | Spouse First Name: | MI: | Sex: | Spouse DOB: | Spouse SSN: |
|---|---|---|---|---|---|
| Child Last Name: | Child First Name: | MI: | Sex: | Child DOB: | Child SSN: |
| Child Last Name: | Child First Name: | MI: | Sex: | Child DOB: | Child SSN: |

## 3 BENEFICIARY DESIGNATION

**FOR EMPLOYEE ONLY: Complete if you have applied for Life / AD&D insurance.**
If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to your named surviving primary beneficiaries. If you have no surviving primary beneficiaries, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%.
(NOTE: Employee is the beneficiary of proceeds received from spouse or child coverage)

| | First Name | Last Name | SSN: | DOB: | Percentage: |
|---|---|---|---|---|---|
| Primary | | | | | |
| Primary | | | | | |
| Contingent | | | | | |
| Contingent | | | | | |

I hereby request to be insured and authorize deductions, if any, from my compensation. These contributions are for my share of the cost of the benefits to which I may be entitled under the group policy(ies). I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I leave employment my coverage will terminate. I understand that if I choose to waive now but enroll at a later date, my cost may be higher and a health questionnaire may be required.

EMPLOYEE SIGNATURE: _____ DATE: _____

## 4 WAIVER OF COVERAGE

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements made by my employer.

EMPLOYEE SIGNATURE: _____ DATE: _____