

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
GROUP LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE
 FOR MEDICAL SCHOOL FACULTY IN MEDICAL COMPENSATION PLAN OR GENERAL HEALTH SCIENCES COMPENSATION PLAN

IMPORTANT

An Evidence of Insurability Form and Health Statement must accompany this application in the following cases:

- Initial application for coverage at 4 X annual supplemental earnings
- Application for any level of voluntary coverage or an *increase* in voluntary coverage after the initial 30-day enrollment period
- Reapplication for any previously declined additional coverage

THIS SECTION TO BE COMPLETED BY FACULTY MEMBER

THIS SECTION TO BE COMPLETED BY DEPARTMENT IN SCHOOL OF MEDICINE

FACULTY MEMBER INFORMATION

NAME: _____
Last First Middle Initial

EMPLOYEE ID NO.: _____ BIRTHDATE: _____
mm-dd-yy

SOCIAL SECURITY NO.: _____ SEX: (M) _____ (F) _____

BASIC COVERAGE

Equal to 1 X your annual supplemental (i.e., Y) earnings. This coverage is employer-paid.

_____ CHECK HERE IF YOU PREFER BASIC COVERAGE *ONLY*

VOLUNTARY COVERAGE

You may apply for additional coverage as follows. This employee-paid coverage is *in addition* to the employer-paid coverage described above. CHECK DESIRED COVERAGE OPTION:

- _____ 1 X YOUR ANNUAL SUPPLEMENTAL (i.e., Y) EARNINGS
- _____ 2 X " "
- _____ 3 X " "
- _____ 4 X " "

BENEFICIARY

(If there is more than one beneficiary, attach a separate, signed sheet)

NAME: _____

ADDRESS: _____

I hereby (1) request that coverage for which I am eligible under the above group policy (policies) issued by the Fortis Benefits Insurance Company; (2) authorize the required deductions, if any, from my earnings; (3) designate the beneficiary named on this form to receive the benefits, if any, payable in the event of my death; and (4) certify that the above birth dates are correct.

Signature _____

Date _____

ANNUAL INCOME

ANNUAL SUPPLEMENTAL INCOME : \$ _____

EFFECTIVE DATE

BASIC LIFE _____ VOLUNTARY LIFE _____
mm-dd-yy mm-dd-yy

TRANS CODE	EMPLOYEE I.D. NO.	EFFECTIVE DATE	ELEMENT NO.	BAL. CD	AMOUNT
1 2	4 12	13 18	19 22	23	24 30

APPROVAL

DEAN'S OFFICE: _____

DATE: _____