



Roger Williams University Enrollment Form

Group Life Insurance

Please return completed form to your benefits department

Employer Name	Group Policy Number
Roger Williams University	01-B84W1F
Employer Address (City, State, ZIP Code)	Coverage Effective Date
1 Old Ferry Road, Bristol, RI 02809	

Employee Name (Last, First, Middle)			
Address (City, State, ZIP Code)			
Social Security Number	Date of Birth (MM/DD/YY)	Gender	Marital Status
		<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Hire Date (MM/DD/YY)	Annual Salary	Type of Enrollment	
	\$	<input type="checkbox"/> New Employee <input type="checkbox"/> Qualified Life Event	<input type="checkbox"/> Annual/Open Enrollment <input type="checkbox"/> Rehire Rehire Date:

Coverage Elections

Please indicate your coverage elections below. The Employee must enroll in Optional Life and Accidental Death & Dismemberment (AD&D) coverage to elect Optional Dependent Life and AD&D coverage. The Optional Spouse Benefit cannot be greater than the Employee Optional Benefit. Evidence of Insurability may be required. Please see your plan booklet for additional information.

Type of Coverage	Selection	Coverage Elected
Employee Optional Life and AD&D	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Spouse Optional Life and AD&D	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$
Child(ren) Optional Life and AD&D	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$

If electing for Dependent coverage (Spouse and Child), please complete the following:

Spouse Name:	Date of Birth:
Child Name:	Date of Birth:
Child Name:	Date of Birth:
Child Name:	Date of Birth:
Child Name:	Date of Birth:

Dependent Child(ren) coverage is available to eligible dependent child(ren) under 26 years of age.

Employee Signature and Authorization

<input type="checkbox"/>	ACCEPT: I declare that all information given in this enrollment form is true and complete to the best of my knowledge and belief. I request coverage under my employer's plan of benefits as indicated above. I authorize my employer to deduct from my earnings my contributions for the coverage(s) selected. I understand that with respect to coverages I have declined, Lincoln Financial Group has the right to require Evidence of Insurability in order to consider any later request to change this decision and that my request may be denied. I am an employee in active employment working at the employer's regular place of business.
<input type="checkbox"/>	DECLINE: I hereby decline all optional coverage as offered by my employer. I certify that I have been given the opportunity by my employer to enroll for coverage. I understand that Lincoln Financial Group has the right to require Evidence of Insurability in order to consider any later request to change this decision and that my request may be denied. I am an employee in active employment working at the employer's regular place of business.
Employee Signature:	Date:

Completion of this enrollment form does not guarantee coverage. Evidence of Insurability may be required. Please see your plan booklet for additional information.

Submit completed form to your employer and retain a copy for your records.