



46 State House Station
 Augusta, ME 04333-0046
 Telephone: (207) 512-3100
 Toll-free: 1-800-451-9800
 TTY: (207) 512-3102

REQUEST FOR BASIC AND/OR ADDITIONAL INSURANCE COVERAGE REQUIRING EVIDENCE OF INSURABILITY

PLEASE TYPE OR CLEARLY PRINT:

Employee Name: _____

Mailing Address: _____

Date: _____

	-		-	
Social Security Number				

Employee is presently employed as a: State Employee Teacher Participating Local District Employee

Date of Birth: _____ Date of Hire: _____ Annual Salary: \$ _____

Employee already has the following coverages: (Check all that apply)

NONE BASIC SUPPLEMENTAL: One Two Three DEPENDENT: A B

Evidence of Insurability is for the following requested coverage(s):

<input type="checkbox"/> BASIC	<input type="checkbox"/> SUPPLEMENTAL	<input type="checkbox"/> DEPENDENT PLAN A	<input type="checkbox"/> DEPENDENT PLAN B																
Equals my gross salary rounded up to the next highest \$1,000	<input type="checkbox"/> One (doubles your Basic) <input type="checkbox"/> Two (triples your Basic) <input type="checkbox"/> Three (quadruples your Basic)	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Spouse</td><td style="text-align: right;">\$5,000</td></tr> <tr><td>* Full-time, unmarried student to age 22</td><td style="text-align: right;">\$5,000</td></tr> <tr><td>* Children, 6 months to age 19</td><td style="text-align: right;">\$5,000</td></tr> <tr><td>* Children, 0 to 6 months</td><td style="text-align: right;">\$1,000</td></tr> </table>	Spouse	\$5,000	* Full-time, unmarried student to age 22	\$5,000	* Children, 6 months to age 19	\$5,000	* Children, 0 to 6 months	\$1,000	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>Spouse</td><td style="text-align: right;">\$10,000</td></tr> <tr><td>* Full-time, unmarried student to age 22</td><td style="text-align: right;">\$ 5,000</td></tr> <tr><td>* Children, 6 months to age 19</td><td style="text-align: right;">\$ 5,000</td></tr> <tr><td>* Children, 0 to 6 months</td><td style="text-align: right;">\$ 2,500</td></tr> </table>	Spouse	\$10,000	* Full-time, unmarried student to age 22	\$ 5,000	* Children, 6 months to age 19	\$ 5,000	* Children, 0 to 6 months	\$ 2,500
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Employer Name: _____

Payroll Clerk: _____

Address: _____

THE ABOVE INFORMATION MUST BE COMPLETED IN ORDER FOR YOUR REQUEST TO BE PROCESSED.

PLEASE NOTE:

You may not insure a dependent who is already insured as an active or retired member of the Group Life Insurance Program. If both parents are Group Life Insurance participants, any child(ren) they may have may be insured as dependents of one parent only. *Step-children may not be covered as dependents.

Please return the completed form to Survivor Services at the address printed at the top of this form. To receive the coverages requested above, you must produce an Evidence of Insurability at your own expense and in accordance with the requirements of the insurance underwriter. Increased coverage becomes effective as of the first day of the first month following the completion of one month of employment after the date of approval.

Employee's Signature: _____ Date: _____

PLEASE RETAIN A COPY FOR YOUR RECORDS

OFFICE USE ONLY: Date Approved: _____ Coverage Applied: _____ New Code: _____

**INSTRUCTIONS FOR:
REQUEST FOR BASIC AND/OR ADDITIONAL INSURANCE
REQUIRING EVIDENCE OF INSURABILITY
(Form #: GI-0874)**

Please type or clearly print (in ink) all of the following information in a legible manner.

- **Employee Name:** Enter the employee's full name.
- **Mailing Address:** Enter the employee's complete mailing address.
- **Date:** Enter the date the employee is completing this form.
- **Social Security Number:** Enter the employee's nine-digit Social Security Number
- **Employee is presently employed as a:** Check the box that applies.
- **Date of Birth:** Enter the employee's date of birth in the following format: two digit month – two digit day – four digit year.
- **Date of Hire:** Enter the date the employee was hired in the following format: two digit month – two digit day – four digit year.
- **Annual Salary:** Enter the amount of the employee's annual salary.
- **Employee already has the following coverages:** Check the box(es) of the insurance coverage the employee currently has in effect.
- **Evidence of Insurability is for the following requested coverage(s):** Check the box(es) of the insurance coverage the employee is requesting.
- **Employer Name:** Enter the employer's name (Example: Department of Labor, Augusta School Department, or City of Bangor)
- **Payroll Clerk:** Enter the payroll clerk's name.
- **Address:** Enter the employer's address.
- **Employee's Signature:** This line is for the employee's signature.
- **Date:** Enter the date the form was signed by the employee.