Five Colleges, Inc. Enrollment Form

Group Life and Disability Insurance

Please return completed form to your benefits department

Employer Name	Group Policy Number
Five Colleges, Inc.	01-B6W1V5
Employer Address (City, State, ZIP Code)	Coverage Effective Date
97 Spring Street, Amherst, MA 10100	

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

Coverage Elections

Please indicate your coverage elections below. The Employee must enroll in Optional Life coverage to elect Optional Dependent Life coverage. <The Optional Spouse Benefit cannot be greater than 50 of the Employee Optional Benefit. All dependents will be covered. Evidence of Insurability may be required. Please see your plan booklet for additional information.

Type of Coverage	Selection	Coverage Elected
Employee Optional Long-Term Disability (Buy Up)	☐ Yes ☐ No	%
Employee Optional Life	☐ Yes ☐ No	$
Spouse Optional Life	☐ Yes ☐ No	$
Child(ren) Optional Life	☐ Yes ☐ 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 19 years of age, or 25 if a full-time student.	

Employee Signature and Authorization	
☐	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, Liberty Mutual Insurance 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.
☐	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 Liberty 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:

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

Group products and services are offered by Liberty Life Assurance Company of Boston, a Liberty Mutual company. Home Office: Boston, MA

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

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