



# Individual & Family Life Insurance Form (Policy #32871-G)

## Enhanced Enrollment Opportunity and Annual Option to Increase Life Insurance Coverage

The **Enhanced Enrollment Opportunity** (September 30, 2024 - October 25, 2024) allows you to enroll in or increase your existing employee coverage up to \$100,000 in \$5,000 increments.

The **Annual Increase Option (AIO) period** (September 30 – October 25, 2024) allows you to increase your spouse / domestic partner and/or child coverage. You must have spouse / domestic partner and/or child coverage in force under this plan to participate in the Annual Increase Option period.

To increase your coverage, complete and **return this form to your benefits contact by 4:30 pm on October 25, 2024.**

**Current Coverage Level:** You can review your current coverage level by logging into [my.wisconsin.edu](http://my.wisconsin.edu) then navigating to the Benefits and Well-Being tile and selecting Benefit Enroll Confirmation.

**Coverage may be increased by the following amounts:**

- **Employee:** Enroll or increase existing coverage up to \$100,000 in \$5,000 increments (Maximum coverage level: **\$300,000**)
- **Spouse or Domestic Partner:** \$5,000 or \$10,000 (Maximum coverage level: **\$150,000**)
- **Child(ren):** \$2,500 (Maximum coverage level: **\$25,000**)

*Your spouse / domestic partner or child coverage cannot exceed your level of employee coverage.*

**The increased coverage level is effective January 1, 2025** (new premium deducted from January earnings).

**Insured Employee Information:**

Insured Employee Name (last, first, middle)	Spouse / Domestic Partner Name (last, first, middle)
Daytime Telephone Number	Employee ID (8 digits)

**Elect Coverage Level Increase** (choose one under each coverage level, if applicable):

<i>Increase my coverage by the following amount(s). Employee coverage limited to \$100,000.</i>	<input type="checkbox"/> <b>Employee Coverage Level: (Select or enter amount to enroll in or increase coverage by)</b>	
	<input type="checkbox"/> <b>Spouse/Domestic Partner Coverage Level:</b>	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000
	<input type="checkbox"/> <b>Child(ren) Coverage Level:</b>	<input type="checkbox"/> \$2,500

**Signature (Sign here and return completed application to your institution benefits contact):**

I have read the above information and elect to increase my life insurance coverage amount(s) per the amounts checked above. I agree to the provisions of the plan and hereby authorize deduction of the monthly premium from my salary.

Employee Signature	Date (mo/day/yr)
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**Additional Information:**

- Individual & Family Life Insurance Plan information, premiums, and forms: [www.wisconsin.edu/ohrwd/benefits/life/if/](http://www.wisconsin.edu/ohrwd/benefits/life/if/)
- Certificate of Insurance: [www.wisconsin.edu/ohrwd/benefits/download/life/if/l&Fcert.pdf](http://www.wisconsin.edu/ohrwd/benefits/download/life/if/l&Fcert.pdf)
- To **decrease or cancel coverage**, submit a paper application ([www.wisconsin.edu/ohrwd/benefits/download/life/if/app.pdf](http://www.wisconsin.edu/ohrwd/benefits/download/life/if/app.pdf)) to your benefits contact at any time.

For Office Use Only					
Date Received:	Received by:	Processor Initials:	Coverage effective date: <b>1/1/2025</b>	Employee ID:	
Current & New Coverage Levels (effective 1/1/2025)					
2024 Coverage Amount	2025 Coverage Amount (NEW)	2024 Coverage Amount	2025 Coverage Amount (NEW)	2024 Coverage Amount	2025 Coverage Amount (NEW)
Employee: \$	\$	Sp/DP: \$	\$	Child: \$	\$

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