

GROUP LIFE INSURANCE ~ SUPPLEMENTAL

NAME OF EMPLOYEE (Last) (First) (Middle)			DATE OF BIRTH	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE
SS#	Employer: SUFFOLK UNIVERSITY		Annual Salary		
Position (Title)			Date Employed or Date in Eligible Category		

Coverage Selection: (Check One)

I authorize the proper deduction from my earnings for insurance coverage at:

- 1 X base annual salary 4 X base annual salary
 2 X base annual salary 5 X base annual salary
 3 X base annual salary (I understand that medical evidence of insurability is required for insurance in the amount of \$375,000 or more.)
 None. (I understand that evidence of insurability satisfactory to the insurer will be required at my own expense if I later apply for additional insurance.)

I understand that this coverage is in addition to the Basic Life Insurance which is at no cost to me.

I DESIGNATE THE BENEFICIARY SHOWN BELOW TO RECEIVE ANY DEATH BENEFITS WHICH MAY BECOME PAYABLE UNDER THE GROUP LIFE INSURANCE POLICY.

Signature	Date
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BENEFICIARY DESIGNATION

Common Terms: My Children -the children born of any and all marriages or legally adopted at any time.
 My Estate -my duly appointed executors or administrators.

Unless otherwise provided:

- (a) if a class of Beneficiaries contains more than one person, the benefits due the Beneficiaries in such class at my death are to be apportioned in equal shares to the living Beneficiaries of the class;
- (b) if all Beneficiaries predecease me, the benefits will be payable to my estate.

Some designations may require alternative documents that the insurer will prepare and return to your employer for your signature.

Primary Designation:	Name	Address	Date of Birth	Relationship
Secondary Designation	Name	Address	Date of Birth	Relationship
(Attach additional pages if necessary)				