



**University of Wisconsin System
Accidental Death and Dismemberment Insurance
Zurich American Insurance Company
Policy GTU 8364005**



PLEASE PRINT

Name (Last, First, Middle)	Social Security Number
Address (Street, City, State, Zipcode)	
UW Campus Name	Date of Birth (Mo/Day/Yr)

Reason for submitting Application (Check all that Apply)

- | | |
|---|--|
| <input type="checkbox"/> New Enrollment | <input type="checkbox"/> Change of Beneficiary |
| <input type="checkbox"/> Change in Coverage | <input type="checkbox"/> Change of Name |
| <input type="checkbox"/> Cancellation of Coverage | |

Monthly Cost

Plan I---Employee Only coverage is \$.029 for each \$1,000.
Plan II---Family Plan coverage is \$.044 for each \$1,000.

Benefit Amounts:

Under this plan an employee may purchase a Benefit Amount between \$25,000 and \$250,000.
Note: Amounts applied for in excess of \$200,000 must not exceed ten (10) times your annual salary.

Benefit Amount	Plan I	Plan II
	Employee Only	Family Plan
\$ 25,000	\$ 0.73	\$ 1.10
\$ 50,000	\$ 1.45	\$ 2.20
\$ 100,000	\$ 2.90	\$ 4.40
\$ 150,000	\$ 4.35	\$ 6.60
\$ 200,000	\$ 5.80	\$ 8.80
\$ 250,000	\$ 7.25	\$ 11.00

<i>Check one of the following</i>	<i>Benefit Amount Selected</i>	<i>Monthly Cost</i>
<input type="checkbox"/> PLAN I -- Employee Only	\$	\$
<input type="checkbox"/> PLAN II -- Family Plan*	\$	\$

*A Domestic Partner Affidavit, if applicable, check one: Is included with application Is on file

View the certificate of coverage at <http://www.uwsa.edu/hr/benefits/ins/laddcert.pdf>.
Access and print your Zurich Travel Assist ID Card at <http://www.uwsa.edu/hr/benefits/ins/laddtrcd.pdf>.

Beneficiary Name	Relationship
Beneficiary Address	

If there is no named beneficiary, or the named beneficiary does not survive you, any benefit payable will be paid in accordance with the standard sequence provided in the certificate. You may add more beneficiaries by attaching a signed and dated listing to this application. You are the beneficiary for your spouse or domestic partner and dependent children.

I authorize the deduction from my salary of the premiums for the insurance applied for as shown above.	
Date (Mo/Day/Yr)	Employee signature

Submit the completed enrollment to your Institution Payroll or Benefits Office.

For Office Use Only:

					Group Number GTU 8364005
Date Received by Employer (Mo/Day/Yr)	Received By:	Hire Date (Mo/Day/Yr)	Coverage Effective Date	Premium	Processor Initials
				\$	

Original – UW System HR

Copy 2 – Campus

Copy 3 – Employee