ARCHDIOCESE OF NEW YORK

THE HARTFORD

GROUP NON-CONTRIBUTORY BASIC LIFE ENROLLMENT AND CHANGE FORM

Employee Information

Last Name: _____ **First Name:** _____ **MI:** _____ **SSN:** _____

Date of Birth: _____ **Gender:** ❑ Male ❑ Female **Home Address:** _____ **Apt. #:** _____

City: _____ **State:** _____ **Zip:** _____ **Home Phone:** _____ **Cell Phone:** _____

Email Address: _____ **Marital Status:** ❑ Single ❑ Married - Marriage Date_____ ❑Divorced ❑ Widowed

Date of Hire: _____ **Occupation:** _____ **Annual Salary (Required) $**_____

ADMINISTRATOR USE ONLY - Enrollment Information – *Please check one and list effective date*			
❑ Initial Enrollment	❑ Beneficiary Change	❑ Annual Salary Update	Effective Date of Coverage or Change (mm/dd/yyyy): _____

Primary Beneficiary Designation – Employees reserve the right to change this beneficiary designation at any time upon written submission of a new form.					
Name #1:	DOB:	SSN:	Relationship:		Percentage:
Address:	City:	State:	Zip:	Phone:	
Name #2:	DOB:	SSN:	Relationship:		Percentage:
Address:	City:	State:	Zip:	Phone:	
Contingent Beneficiary Designation – If the beneficiary dies before me, I designate as contingent beneficiary:					
Contingent #1:	DOB:	SSN:	Relationship:		Percentage:
Address:	City:	State:	Zip:	Phone:	

- For additional beneficiaries, please attach a separate list and include the names, addresses, dates of birth, and relationship to the employee.
- Your Basic Life Insurance benefit will be reduced by 35% on the date you attain age 66 and 50% when you attain age 70.
- If there is more than one beneficiary or more than one contingent beneficiary, they will share the death benefits equally, or all will be paid to the survivor.

Employee (Participant) Signature: _____ **Print Name:** _____ **Date:** _____

EMPLOYER INFORMATION:

Institution Name: _____ **Institution/Department #:** _____/_____ **Division Code:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Employer Contact Phone Number: _____ **Employer Contact Email Address:** _____

Employer Signature: _____ **Employer Print Name:** _____ **Date:** _____

ADMINISTRATORS: Please send completed form to Employee Benefit Connections at ebc@archny.org. **For any questions or further assistance, please call (646)794-3060.**