AMHERST COLLEGE
OFFICE OF HUMAN RESOURCES
P.O. BOX 5000
AMHERST, MA 01002-5000

Request for Group Life Insurance Effective Date: _____

Name: _____ **Date of Birth: _____**

☒ Basic Coverage

Supplemental Coverage

- ☐ 1 x Salary
- ☐ 2 x Salary
- ☐ 3 x Salary
- ☐ 4 x Salary
- ☐ 5 x Salary

☐ Spouse Coverage - $10,000

☐ Child Coverage - $10,000

My signature below signifies my agreement with the statements and authorization under Certification and Authorization below.

Signature _____ Date _____

- I certify that all information on this form is true and complete to the best of my knowledge and belief. I understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the group policy and summarized in the announcement material provided me and the certificate of coverage provided to me.
- I understand that the effective date of insurance for myself or for any of my dependents is subject to the dependent health condition requirements of the Plan.
- Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until the Insurer gives its written consent.
- I request my employer to arrange for the issuance of Group Life Coverage for which I am or may become eligible and authorize deductions of the required contributions from my earnings.