Accidental Death & Dismemberment
Enrollment Form – Domestic Partnership

NAME

EMPL ID#

EMAIL ADDRESS

DAYTIME PHONE

Accidental Death & Dismemberment Insurance

This optional insurance allows employees to insure themselves and eligible family members against covered accidents in an amount up to $500,000. Dependents covered under this plan are covered only for a specified percentage of the employee’s elected coverage. (See Plan Booklet for specific details.) No proof of insurability is needed at any time for this option.

Select one of the following options:

[ ] Employee Only Coverage ($.19 per $10,000 of coverage)

[ ] Family Coverage ($.36 per $10,000 of coverage)

Coverage amount desired $_________________

Primary Beneficiary:________________________ Relationship to Employee:________________________

Contingent Beneficiary:________________________ Relationship to Employee:________________________

(Employee is the beneficiary for coverage on family members)

I wish to enroll in Accidental Death and Dismemberment Insurance through the University of Utah. I certify the information I have provided on all parts of this form is true and correct. I understand coverage will be effective the first day of the month following the date I submit my completed form to the University Benefits Department or on the day I submit my form if it is the first day of the month. I hereby authorize payroll deductions of premiums as required.

I certify that my Domestic Partner and I are both over the age of 18; reside together in a permanent residence and have done so for at least six months and will remain members of the same household for the period of coverage; have a serious and committed relationship which we intend to continue indefinitely; are emotionally committed to one another and jointly responsible for the common welfare and financial obligations of our household or one of us is chiefly dependent upon the other for financial assistance; not related in any way that would prohibit legal marriage; and not legally married to anyone else or the partner of anyone else. I acknowledge that if we fail to meet any of these conditions in the future, my Domestic Partner and his/her children will no longer be eligible for coverage under this plan.

Employee Signature:________________________ Date:________________________

For Benefits Department Use Only

<table>
<thead>
<tr>
<th>Benefit Program</th>
<th>[ ] Original</th>
<th>[ ] Amendment</th>
<th>TOTAL DESIRED COVERAGE</th>
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</thead>
<tbody>
<tr>
<td>Effective Date:</td>
<td></td>
<td>CURRENT COVERAGE:</td>
<td>(Indicated Above)</td>
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<td></td>
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<td>AD/D___________</td>
<td>Effective Date:</td>
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