

Employee's Refusal of Increase in Amount of Optional and/or Contributory Life Insurance Group Plans

GuideStone Financial Resources of the Southern Baptist Convention

Return completed form to: Insurance Operations — Group Plans
GuideStone Financial Resources, SBC
2401 Cedar Springs Road
Dallas, TX 75201-1498

1. GENERAL INFORMATION

Employer name: _____ Effective date of change: ____/____/____

Employee name: _____ Social Security number: _____

Refusal of increase

I do **not** wish to take advantage of the increase to which I am entitled because of a change in my Annual Rate of Basic Earnings and request that my coverage be continued at the former amount(s). I understand that if I wish to request this or additional coverage for which I may become eligible at a later date, I will be required to furnish, at my own expense, for myself (and for eligible dependents, if an increase in such coverage is also requested) evidence of insurability to the insurance company. This Refusal of Increase applies to:

- Employee basic term life insurance Employee optional term life insurance

I understand that the coverage I did not request (refused) is not available for me, even if it appears in my Benefit Booklet or Schedule of Benefits.

Employer's authorized representative: _____ Date: ____/____/____

Employee's signature: _____ Date: ____/____/____

Refusal of contributory portion of employer basic life insurance

I elect to take only the portion of Employee Basic Term Life coverage paid for by my employer.

I do not wish to take advantage of the additional contributory portion of Employee Basic Term Life coverage available. I understand that if I wish to request this or additional coverage for which I may become eligible at a later date, I will be required to furnish, at my own expense, for myself (and for eligible dependents, if an increase in coverage is also requested) evidence of insurability to the Insurance Company.

I understand that the coverage I refused is not available to me, even if it appears in my Benefits Booklet or Schedule of Benefits.

Employer's authorized representative: _____ Date: ____/____/____

Employee's signature: _____ Date: ____/____/____

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Processed by: _____ Date: ____/____/____

