

# Life Insurance Enrollment Form

*INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee.*

|  |              |                              |  |
|--|--------------|------------------------------|--|
| Name of Employer/Plan Sponsor<br>CSAC Excess Insurance Authority   |              | Group/Plan Number<br>31640-7 | Account Number/Location<br>133 - County of Humboldt  |
| Class/Occupation   | Date of Hire | Annual Salary                | Employment Status: <input type="checkbox"/> Active Full-Time <input type="checkbox"/> Retired<br><input type="checkbox"/> Active Part-Time |
| This change is due to: (check all that apply) <input type="checkbox"/> Change in Coverage Amount <input type="checkbox"/> Other: _____<br><input type="checkbox"/> Initial Eligibility Following Hire <input type="checkbox"/> Late Entrant* |              |                              | Effective Date of Coverage or Change:  |

*\*A late entrant is an individual who is first enrolling for supplemental or dependent coverage after the first available opportunity.*

## Employee Information

|  |  |                      |                                   |                 |
|--|--|----------------------|-----------------------------------|-----------------|
| Employee Name (last, first, middle initial)              | <input type="checkbox"/> Female<br><input type="checkbox"/> Male | Date of Birth<br>/ / | Social Security #                 | Employee I.D. # |
| Employee Address (street address, city, state, zip code) |  |                      | Telephone<br>Work ( )<br>Home ( ) |                 |

## Employee Life Insurance

|                            |  |
|----------------------------|--|
| Basic Life                 | <input checked="" type="checkbox"/> Employee Only—Elect Coverage (Note: Basic Life insurance is employer provided.)  |
| Supplemental Life          | Guaranteed Issue (GI) Limit = \$125,000. When you are first eligible for supplemental life coverage, you can elect up to the GI Limit without evidence of insurability. At each annual enrollment, if you have current supplemental life coverage you can elect to increase supplemental life coverage by one plan increment (total coverage not to exceed the GI Limit) without evidence of insurability. Total supplemental life coverage up to \$500,000 is available if you complete an Evidence of Insurability form subject to approval by ReliaStar Life. |
| Supplemental Life Election | I currently have supplemental life coverage of: \$_____<br><br>I am applying for additional supplemental life coverage of: \$_____. (\$10,000 increments)<br><br>Total supplemental life coverage (current plus additional): \$_____<br><br><input type="checkbox"/> Waive Coverage  |

## Employee Accidental Death & Dismemberment Insurance

|                            |   |
|----------------------------|---|
| Basic AD&D                 | <input checked="" type="checkbox"/> Employee Only—Elect Coverage (Note: Basic AD&D insurance is employer provided.)                       |
| Supplemental AD&D Election | <input type="checkbox"/> Amount equal to supplemental life insurance coverage up to \$500,000.<br><input type="checkbox"/> Waive Coverage |

## Beneficiary Information *Designate your beneficiary(ies) below.*

|  |                                  |                          |              |
|--|----------------------------------|--------------------------|--------------|
| Name of Beneficiary (last name, first, middle initial) | <input type="checkbox"/> Primary | Relationship to Employee | Benefit %    |
| Address  | Date of Birth                    | Social Security Number   | Phone Number |

|  |  |                          |              |
|--|--|--------------------------|--------------|
| Name of Beneficiary (last name, first, middle initial) | <input type="checkbox"/> Primary <input type="checkbox"/> Contingent | Relationship to Employee | Benefit %    |
| Address  | Date of Birth  | Social Security Number   | Phone Number |

|  |  |                          |              |
|--|--|--------------------------|--------------|
| Name of Beneficiary (last name, first, middle initial) | <input type="checkbox"/> Primary <input type="checkbox"/> Contingent | Relationship to Employee | Benefit %    |
| Address  | Date of Birth  | Social Security Number   | Phone Number |

**SEE OTHER SIDE**

**Dependent Spouse/Domestic Partner (DP) Life Insurance**

|  |  |
|--|--|
| <b>Spouse/(DP) Life</b><br><br>Date of Birth ___/___/___<br><br>Name _____ | When you are initially eligible for dependent spouse/(DP) coverage, you can elect up to \$30,000 in coverage without evidence of insurability. Total spouse/(DP) coverage up to \$500,000 is available if your spouse/(DP) completes and Evidence of Insurability form subject to approval by ReliaStar Life. Spouse/(DP) coverage cannot exceed 100% of the employee's coverage amount. |
| <b>Spouse/(DP) Life Election</b>   | I currently have spouse life coverage of: \$_____.<br><br>I am applying for additional spouse life coverage of: \$_____. ( <i>\$10,000 increments</i> )<br><br>Total spouse life coverage (current plus additional): \$_____.<br><br><input type="checkbox"/> Waive Coverage   |

*Note: The employee is the beneficiary for any dependent spouse/(DP) insurance coverage.*

**Dependent Child(ren) Life Insurance**

|                                 |  |
|---------------------------------|--|
| <b>Child(ren) Life</b>          | When you are initially eligible for dependent child(ren) coverage, you can elect it without evidence of insurability. At all other times, you must complete an Evidence of Insurability form for your child(ren) subject to approval by ReliaStar Life. Children are eligible from birth to 20 years of age (through 24 years if a full-time student). |
| <b>Child(ren) Life Election</b> | <input type="checkbox"/> \$10,000 for each eligible dependent child.<br><input type="checkbox"/> Waive Coverage  |

*Note: The employee is the beneficiary for any dependent child(ren) insurance coverage.*

**READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW**

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

|                      |                        |
|----------------------|------------------------|
| Employee's Signature | Date Signed<br><br>/ / |
|----------------------|------------------------|