

# Life and Disability Income Insurance Enrollment Form

*INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder of this form to be completed by the Employee. If you elect Life coverage outside of the initial eligibility enrollment period or apply for an increase in life coverage, then you must provide evidence of insurability subject to approval by ReliaStar Life.*

Name of Employer/Plan Sponsor County of Stanislaus		Group/Plan Number 316407	Account Number/Location #50
Class/Occupation	Date of Hire	Annual Salary	Employment Status: <input type="checkbox"/> Active Full-Time <input type="checkbox"/> Retired <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: _____ <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 Life coverage after the first available opportunity.

## Employee Information

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

## Disability Income Coverage

Monthly Income Benefits (LTD)	<input type="checkbox"/> Management Employees Only Elect Coverage (Note: LTD coverage is employer provided.)
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## Employee Life Insurance

Basic Life Employee only	<input type="checkbox"/> All Other Active Full-Time Employees, except County Attorneys, Department Heads, Management, Confidential Employees and Resident Physicians <input type="checkbox"/> Early Retirees <input type="checkbox"/> County Attorneys <input type="checkbox"/> Department Heads and Management Employees <input type="checkbox"/> Resident Physicians <input type="checkbox"/> Department Heads and Management Employees <input type="checkbox"/> Stanislaus Consolidated Fire Protection District Elect Coverage (Note: Basic Life insurance is employer provided.)
Supplemental Life with Portability	Guaranteed Issue (GI) Limit = \$100,000 (Option 4). When you are first eligible (within 31 days) for Supplemental Life coverage, you can elect up to the GI Limit without evidence of insurability. Total Supplemental Life coverage up to \$300,000 is available if you complete an Evidence of Insurability form subject to approval by ReliaStar Life. Supplemental Life Insurance coverage must not exceed 5 times annual salary.
Supplemental Life and Supplemental AD&D Election Employee only	I currently have Supplemental Life and Supplemental AD&D coverage Option _____ = \$ _____  I am applying for additional Supplemental Life and Supplemental AD&D coverage of: <input type="checkbox"/> Option 1: \$20,000 <input type="checkbox"/> Option 2: \$30,000 <input type="checkbox"/> Option 3: \$50,000 <input type="checkbox"/> Option 4: \$100,000 <input type="checkbox"/> Option 5: \$150,000 <input type="checkbox"/> Option 6: \$200,000 <input type="checkbox"/> Option 7: \$250,000 <input type="checkbox"/> Option 8: \$300,000  Total Supplemental Life and Supplemental AD&D coverage (current plus additional): \$ _____. <input type="checkbox"/> Waive (Note: Supplemental Life and Supplemental AD&D insurance is employee paid)

## Employee Accidental Death & Dismemberment Insurance

Basic AD&D	<input checked="" type="checkbox"/> Class 1, 2 and 3 Employees Only. (Note: Basic AD&D insurance is employer provided.)
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**Beneficiary Information** *Designate your beneficiary(ies) below.*

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

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

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

**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
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