Life Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. All new coverage or any increases in Life coverage will require evidence of insurability (proof of good health) if plan participation requirements are not met.

Name of Employer/Plan Sponsor **City and County of San Francisco Health Service Systems**		**Group/Plan Number** **29504-3**	**Account Number/Location** **2- MEA**
Class/Occupation	**Date of Hire** *(mm/dd/yyyy)*	**Annual Salary**	**Employment Status:** ☐ Active Full-Time ☐ Active Part-Time ☐ Retired
This change is due to: *(check all that apply)* ☐ Initial Eligibility Following Hire ☐ Late Entrant* ☐ Change in Coverage Amount ☐ Other: ______________________			**Effective Date of Coverage or Change:**

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

Employee Information

Employee Name *(last, first, middle initial)*		Date of Birth *(mm/dd/yyyy)*	Social Security #	Employee I.D. #
Employee Address *(street address, city, state, zip code)*	Work Phone Number	Home Phone Number		☐ Female ☐ Male

Employee Life Insurance

Basic Life	☑ Employee Only—Elect Coverage *(Note: Basic Life insurance is employer provided.)*
Supplemental Life	Guaranteed Issue (GI) Limit = $50,000. 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 $10,000 (total coverage not to exceed 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 Election	I currently have supplemental life coverage of: $____________. I am applying for additional supplemental life coverage of: $____________. *($10,000 increments)* Total supplemental life coverage (current plus additional): $____________. ☐ Waive

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

Name of Beneficiary *(last name, first, middle initial)*	☑ **Primary**	Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Name of Beneficiary *(last name, first, middle initial)*	☐ Primary ☐ 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 *(mm/dd/yyyy)*