Life Insurance Enrollment Form

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

Name of Employer/Plan Sponsor			Group/Plan Number	Account Number/Location
County of Tehama			316407	#52
Class/Occupation	**Date of Hire**	**Annual Salary**	**Employment Status:**	☐ Active Full-Time ☐ Retired ☐ Active Part-Time
This change is due to: (check all that apply) ___Change in Coverage Amount ___Other: ____________ ___ Initial Eligibility Following Hire ___Late Entrant*				**Effective Date of Coverage or Change:**

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

Employee Information

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

Employee Life Insurance

Basic Life Employee only	☐ Class 1: Active Management, LEMA, DSA, Misc Bargaining Unit employees and Peace Officers' Bargaining Unit ☐ Class 2: All Other Active Employees ☐ Class 3: Retirees ☐ Class 4: Retirees - Management & LEMA ☐ Class 5: Court Misc. Employees *(Note: Basic Life/Basic AD&D insurance is employer provided.)*

Employee Accidental Death & Dismemberment Insurance

Basic AD&D	☒ Employee Only—Elect Coverage *(Note: Basic AD&D insurance is contributory or non contributory based on the Basic Life Insurance Election above.)*

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

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 / /