

Full Time-Sullivan County Group Term Life Insurance Election/Beneficiary Form

Basic Term Life Insurance (\$26,000-County Paid Policy for Employee)

Type of Change:

- New Enrollment
 Beneficiary Change
 Change in Coverage
 Name/Address Change

Name: _____	Department: _____
Address: _____	Birthdate: _____
SS# _____	Full time Hire Date: _____
Home Phone: _____	Salary: _____
	Work Phone: _____
	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female

I **Waive** option to purchase Supplementary Life Insurance

I **Elect** the option to purchase Supplementary Life Insurance through payroll deductions as marked below:

Benefit	Monthly Cost	Benefit	Monthly Cost
<input type="checkbox"/> \$10,000	\$2.20	<input type="checkbox"/> \$60,000	\$13.20
<input type="checkbox"/> \$20,000	\$4.40	<input type="checkbox"/> \$70,000	\$15.40
<input type="checkbox"/> \$30,000	\$6.60	<input type="checkbox"/> \$80,000	\$17.60
<input type="checkbox"/> \$40,000	\$8.80	<input type="checkbox"/> \$90,000	\$19.80
<input type="checkbox"/> \$50,000	\$11.00	<input type="checkbox"/> \$100,000	\$22.00

Primary Beneficiary:

Name: _____ SSN# _____ DOB: _____

Address: _____ Relationship: _____

Contingent Beneficiary:

Name: _____ SSN# _____ DOB: _____

Address: _____

Relationship: _____ Percentage: _____

Name: _____ SSN# _____ DOB: _____

Address: _____

Relationship: _____ Percentage: _____

Dependent Life Insurance:

- I **Elect** Coverage
 I **Reject** Coverage

Indicate Option Below:

- Option #1-** \$10,000 Spouse Coverage and \$5,000 on each child ages 6 months to 26 years **\$2.60 per month**
- Option #2-** \$20,000 Spouse Coverage and \$10,000 on each child ages 6 months to 26 years **\$5.20 per month**

Dependent Spouse: Gender: Male Female

Name: _____ Birthdate: _____ SSN# _____

****Is Spouse a Sullivan County Government Offices or Sullivan County Dept of Education Employee:** Yes No

Dependent Child: Gender: Male Female

Name: _____ Birthdate: _____ SSN# _____

Dependent Child: Gender: Male Female

Name: _____ Birthdate: _____ SSN# _____

Dependent Child: Gender: Male Female

Name: _____ Birthdate: _____ SSN# _____

Beneficiary for Dependent Life Insurance will be the County employee, unless otherwise stated.

I certify this election form reflects my choice for life insurance benefits, my beneficiaries relating to same and any payroll deductions applicable to the voluntary coverages I have elected to purchase. I understand that this document will replace all prior life insurance documents and beneficiary information, which I have provided to the County and/or any supplemental coverage I have previously purchased through the employee payroll deduction electives.

Employee Signature: _____ Date: _____