Life and AD&D 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. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

Name of Employer/Plan Sponsor Etiwanda School District		Group/Plan Number 66200-3	Account Number/Location 32/33
Class/Occupation	Date of Hire *(mm/dd/yyyy)*	Annual Salary	Employment Status: ☐ Active
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 or dependent 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 = $100,000 or 2 times annual salary, whichever is less. When you are first eligible for supplemental life coverage, you can elect up to the GI Limit without evidence of insurability. Total supplemental life coverage from $10,000 to $500,000 in $10,000 increments, not to exceed 5 times your annual salary, 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

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

Dependent Spouse/Domestic Partner (DP) Life Insurance

Spouse/DP Life	If you are covered for Employee Supplemental Life, you may apply for Dependent Spouse/DP Supplemental Life coverage. When you are initially eligible for Dependent Spouse/DP coverage, you can elect up to $20,000 in coverage without evidence of insurability. Total Spouse/DP coverage from $10,000 to $500,000 in $10,000 increments is available if your Spouse/DP completes an Evidence of Insurability form subject to approval by ReliaStar Life. Spouse/DP coverage is limited to 100% of the employee's coverage amount.
Spouse/DP Name and Date of Birth	Spouse/DP Name ____________________ Spouse/DP Date of Birth ____________
Spouse/DP 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

Note: The employee is the beneficiary for any Dependent Spouse/DP insurance coverage.

Dependent Child(ren) Life Insurance

Child(ren) Life	If you are covered for Employee Supplemental Life, you may elect $2,500, $5,000, or $10,000 of Dependent Children Supplemental Life coverage on your children from age birth to 26 years. 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.
Child(ren) Life Election	I currently have Supplemental Life coverage of: $______________. I am applying for additional Supplemental life coverage of: $____________. Total Supplemental Life coverage (current plus additional): $____________. ☐ Waive

Accidental Death & Dismemberment Insurance (PAI)

Basic AD&D	☑ Employee Only—Elect Coverage *(Note: Basic AD&D insurance is employer provided.)*
Employee Voluntary AD&D (PAI)	Amount of PAI available is $10,000 to $500,000 in $10,000 increments or 10 times your annual salary.
Employee Voluntary AD&D (PAI) Election	I currently have Voluntary AD&D coverage of: $______________. I am applying for additional Voluntary AD&D coverage of: $____________. *($10,000 increments)* Total Voluntary AD&D coverage (current plus additional): $____________. ☐ Waive
Voluntary Dependent AD&D (PAI) Election	☐ Spouse/Domestic Partner Only — Amount equal to 50% of employee's coverage ☐ Child(ren) Only — Amount equal to 15% of employee's coverage ☐ Spouse/Domestic Partner & Child(ren) — Spouse/Domestic Partner equal to 40% of employee's coverage; Child(ren) equal to 10% of employee's coverage ☐ Waive

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 *(mm/dd/yyyy)*