RELIANCE STANDARD LIFE INSURANCE COMPANY

LIFE INSURANCE ENROLLMENT FORM

POLICY #GL129927-00

EMPLOYER/POLICYHOLDER NAME: **TEHAMA COUNTY DEPARTMENT OF EDUCATION**

1135 Lincoln Street, Red Bluff, CA 96080

FOR OFFICE USE ONLY:

EMPLOYEE OCCUPATION/JOB TITLE	EMPLOYEE DATE OF EMPLOYMENT
EFFECTIVE DATE OF COVERAGE	FULL OR PART TIME EMPLOYEE

EMPLOYEE INFORMATION

NAME SEX: M F

STREET ADDRESS CITY STATE ZIP CODE

HOME TELEPHONE NUMBER DATE OF BIRTH MARITAL STATUS

COVERAGE REQUESTED:

EMPLOYEE LIFE/AD&D: $50,000 ☐ YES ☐ NO

DEPENDENT LIFE if applicable (see list below), please check: ☐ YES ☐ NO

SPOUSE: $5,000

NAME: DATE OF BIRTH:

CHILD:

BIRTH TO 6 MONTHS $500

NAME: DATE OF BIRTH:

6 MONTHS TO AGE 21 $5,000

NAME: DATE OF BIRTH:

NAME: DATE OF BIRTH:

NAME: DATE OF BIRTH:

NAME: DATE OF BIRTH:

FULL TIME STUDENT TO AGE 26 $5,000

NAME: DATE OF BIRTH:

NAME: _____ DATE OF BIRTH: _____

NAME: _____ DATE OF BIRTH: _____

NAME: _____ DATE OF BIRTH: _____

RETIREES: No AD&D or Dependent Life available. Amount reduces with age. See Certificate of Coverage for more information.

IMPORTANT NOTE:

Employee is responsible for updating the coverage requested based on changes in their individual circumstances by completing a new life insurance enrollment form as necessary and providing it to the Human Resources Services office in a timely manner.

BENEFICIARY DESIGNATION

Definitions

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named and the specific percentage has not been designated then each will receive an equal share of the benefit.

NAME	ADDRESS	RELATIONSHIP	%

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named and the specific percentage has not been designated, then each will receive an equal share of the benefit.

NAME	ADDRESS	RELATIONSHIP	%

SELECTION/WAIVER OF GROUP INSURANCE

I, the undersigned, and employee of the above named policyholder elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy issued to the policyholder by Reliance Standard Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of insurance (not applicable if the employer pays 100% of the required contribution.)

I hereby waive my right at this time to elect the insurance coverages which I did not select above. I understand that if I do not enroll within 31 days, when first eligible that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability to Reliance Standard Life Insurance Company for approval. I also understand that Reliance Standard Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary (ies) named on this form to receive any benefits payable in the event of my death.

All information submitted by me on this form, to the best of my knowledge and belief, is true and complete.

Employee Signature **Date**