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

Basic Term Life Insurnace ($25,000-Employee Paid Policy)

*Employee must work an averge of 15 hours a week to be eligible to purchase part-time life insurance

Type of Change:

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

☐ I **Waive** option to purchase Employee Term Life Insurance ($25,000 Policy) for **$5.50 per month**

☐ I **Elect** the option to purchase Employee Term Life Insurane ($25,000) for **$5.50 per month**

Effective Date: _____

Name: _____ **Department:** _____

Address: _____ **Birthdate:** _____

_____ **Gender:** ☐ Male ☐ Female

SS# _____ **Hire Date:** _____ **Salary:** _____

Home Phone: _____ **Work Phone:** _____

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 choices for life insurance benefits, my beneficiaries relating to same and any payroll deductions applicable to the voluntary coverage's I have elected to purchase.

Employee Signature: _____ **Date:** _____