Sullivan County Group Term Life Insurance Election/Beneficiary Form

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

For County Commissioners **Effective Date:** __________

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**

Name: ______________________________ **Department:** ______________________

Address: ______________________________ **Birthdate:** ______________________

______________________________ **Gender:** ☐ Male ☐ Female

SS# ______________________ **Commission 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: ______________