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

Effective Date: _____

Name: _____ **Department:** _____

Address: _____ **Birthdate:** _____

_____ **Gender:** ☐ Male ☐ Female

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

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

☐ 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
☐	$10,000	$2.20	☐	$60,000	$13.20
☐	$20,000	$4.40	☐	$70,000	$15.40
☐	$30,000	$6.60	☐	$80,000	$17.60
☐	$40,000	$8.80	☐	$90,000	$19.80
☐	$50,000	$11.00	☐	$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 insurnace 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:** _____