



COUNTY OF SONOMA EMPLOYEE BENEFITS ENROLLMENT/CHANGE FORM

Annual Enrollment
 New Hire/Newly Eligible Date _____
 Event Date _____

EMPLOYEE INFORMATION				FOR COUNTY USE ONLY: Effective Dates	
				Medical _____	Basic Life _____
				Dental _____	Dependent Life _____
				Vision _____	Date entered in eP: _____
				HR Technician Initials: _____	
Last Name		First Name		Middle Name	FTE
Social Security Number	Date of Birth	Check One <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Bargaining Unit
Residential Address (Required) <input type="checkbox"/> Check Box if new address			City	State	Zip Code
Mailing Address <input type="checkbox"/> Check Box if Same as Residential			City	State	Zip Code
Personal Email Address		Work Phone	Personal Phone		Other Phone
Is your spouse/domestic partner/dependent an employee or retired employee of the County of Sonoma? <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Employee	If yes, list name(s): _____	
			<input type="checkbox"/> Retiree		
REASON FOR ENROLLMENT/CHANGE <i>Check ALL Boxes that apply</i>			ADD/DROP/WAIVE DEPENDENT COVERAGE <i>Check ALL Boxes that apply</i>		
<input type="checkbox"/> Annual Enrollment <input type="checkbox"/> New Hire <input type="checkbox"/> Newly Eligible Employee <input type="checkbox"/> Extra Help to Probationary _____ FTE to _____ FTE <input type="checkbox"/> Other _____ <input type="checkbox"/> Bargaining Unit Change Old BU _____ New BU _____ <input type="checkbox"/> Loss of Other Group Coverage <input type="checkbox"/> Reenrollment/Reinstatement <input type="checkbox"/> Cancel Employee Coverage <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change; Previous Name: _____			<input type="checkbox"/> ADD Newly Acquired/Eligible Dependent(s) due to: <input type="checkbox"/> Marriage <input type="checkbox"/> Domestic Partnership <input type="checkbox"/> Birth/ Adoption/ Legal Guardianship <input type="checkbox"/> QMCSO <input type="checkbox"/> Loss of Other Group Coverage <input type="checkbox"/> Other _____ <input type="checkbox"/> Dropping Dependent(s) due to <input type="checkbox"/> Divorce/Legal Separation/Termination of Domestic Partnership <input type="checkbox"/> Gaining Other Group Coverage <input type="checkbox"/> Over-age Dependent <input type="checkbox"/> Other _____		
I ELECT THIS MEDICAL PLAN: <i>(Note - If waiving or declining medical coverage, complete Acknowledgement on page 5 of this form)</i>					Check One:
					<input type="checkbox"/> Employee Only
					<input type="checkbox"/> Employee + 1
					<input type="checkbox"/> Employee + 2 or more
<input type="checkbox"/> Kaiser Traditional HMO (602484-0003)	<input type="checkbox"/> Kaiser Hospital Services DHMO (602484-0006)		<input type="checkbox"/> Kaiser Deductible First HDHP (602484-0009)		
<input type="checkbox"/> Sutter Health Plus HMO (131802-000001)	<input type="checkbox"/> Sutter Health Plus Hospital Services DHMO (131802-000005)		<input type="checkbox"/> Sutter Health Plus Deductible First HDHP (131802-000009)		
<input type="checkbox"/> Western Health Advantage HMO (950201-A000)	<input type="checkbox"/> Western Health Advantage Hospital Services DHMO		<input type="checkbox"/> Western Health Advantage Deductible First HDHP		
<input type="checkbox"/> County Health Plan EPO (175130-M100)	<input type="checkbox"/> County Health Plan PPO (175130-M051)		<input type="checkbox"/> Waive Medical		
Sutter Health Plus (SHP) and Western Health Advantage (WHA) ONLY <i>(If you do not provide a PCP ID # for yourself and your covered dependent(s), a Primary Care Physician will automatically be assigned. For PCP changes only, please contact the Health Plan directly.)</i>					Primary Care Physician (PCP) ID #
DENTAL INSURANCE					Check One:
<input type="checkbox"/> I AM ELECTING DELTA DENTAL PREMIER #3126-0224					<input type="checkbox"/> Employee Only
<input type="checkbox"/> I AM CONTINUING DENTAL COVERAGE					<input type="checkbox"/> Family
<input type="checkbox"/> I AM WAIVING DENTAL COVERAGE					
<input type="checkbox"/> I AM DECLINING/DROPPING DENTAL COVERAGE					

Employee Name: _____

Employee ID: _____

BASIC LIFE INSURANCE #GL-673199 IS PROVIDED TO EMPLOYEES WITH A FTE OF .75 OR GREATER (60 HOURS OR MORE BI-WEEKLY) AS A COUNTY PAID BENEFIT. NEW HIRES ARE REQUIRED TO COMPLETE AND SUBMIT A BENEFICIARY DESIGNATION FORM FOUND ON PAGE 6 OF THIS FORM.

BASIC LIFE INSURANCE (PART TIME EMPLOYEES IN LIMITED BARGAINING UNITS ONLY):

- I AM IN AN ELIGIBLE BARGAINING UNIT [DSA (46,47), SCLEA (30, 40, 41, 70), OR ESC (75)]
- I AM ELECTING THE HARTFORD BASIC LIFE INSURANCE #GL-673199 AT MY OWN EXPENSE
- I AM CONTINUING BASIC LIFE INSURANCE COVERAGE
- I AM DECLINING/DROPPING BASIC LIFE INSURANCE COVERAGE

SUPPLEMENTAL LIFE INSURANCE (AVAILABLE TO PURCHASE BY EMPLOYEES ENROLLED IN BASIC LIFE INSURANCE) SEPARATE [ENROLLMENT FORM](#) IS REQUIRED.

- | | |
|---|---|
| <p>DEPENDENT LIFE INSURANCE</p> <p><input type="checkbox"/> I AM ELECTING DEPENDENT LIFE INSURANCE</p> | <p><input type="checkbox"/> I AM CONTINUING DEPENDENT LIFE INSURANCE</p> <p><input type="checkbox"/> I AM DECLINING/DROPPING DEPENDENT LIFE INSURANCE</p> |
|---|---|

ELIGIBLE DEPENDENT INFORMATION: List ALL person(s) to be covered

Spouse/Domestic Partner:

Last Name, First Name, MI	Medical	Dental	Vision	Dependent Life	Check One	Date of Birth	Social Security (Required)	Relationship
	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Male <input type="checkbox"/> Female			
Mailing Address (If different from Employee)				Permanently Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	IRS Qualified Dependent <input type="checkbox"/> No <input type="checkbox"/> Yes	SHP and WHA Enrollees ONLY		Primary Care Physician ID # Previously Seen <input type="checkbox"/> Yes <input type="checkbox"/> No

Child:

Last Name, First Name, MI	Medical	Dental	Vision	Dependent Life	Check One	Date of Birth	Social Security (Required)	Relationship
	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Male <input type="checkbox"/> Female			
Mailing Address (If different from Employee)				Permanently Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	IRS Qualified Dependent <input type="checkbox"/> No <input type="checkbox"/> Yes	SHP and WHA Enrollees ONLY		Primary Care Physician ID # Previously Seen <input type="checkbox"/> Yes <input type="checkbox"/> No

Child:

Last Name, First Name, MI	Medical	Dental	Vision	Dependent Life	Check One	Date of Birth	Social Security (Required)	Relationship
	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Male <input type="checkbox"/> Female			
Mailing Address (If different from Employee)				Permanently Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	IRS Qualified Dependent <input type="checkbox"/> No <input type="checkbox"/> Yes	SHP and WHA Enrollees ONLY		Primary Care Physician ID # Previously Seen <input type="checkbox"/> Yes <input type="checkbox"/> No

Child:

Last Name, First Name, MI	Medical	Dental	Vision	Dependent Life	Check One	Date of Birth	Social Security (Required)	Relationship
	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Male <input type="checkbox"/> Female			
Mailing Address (If different from Employee)				Permanently Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	IRS Qualified Dependent <input type="checkbox"/> No <input type="checkbox"/> Yes	SHP and WHA Enrollees ONLY		Primary Care Physician ID # Previously Seen <input type="checkbox"/> Yes <input type="checkbox"/> No

Child:

Last Name, First Name, MI	Medical	Dental	Vision	Dependent Life	Check One	Date of Birth	Social Security (Required)	Relationship
	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Add <input type="checkbox"/> Continue <input type="checkbox"/> Delete <input type="checkbox"/> Waive	<input type="checkbox"/> Male <input type="checkbox"/> Female			
Mailing Address (If different from Employee)				Permanently Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No	IRS Qualified Dependent <input type="checkbox"/> No <input type="checkbox"/> Yes	SHP and WHA Enrollees ONLY		Primary Care Physician ID # Previously Seen <input type="checkbox"/> Yes <input type="checkbox"/> No

SIGNATURE REQUIRED - Sign the applicable Agreement for the Health Plan Provider you selected. Failure to sign will result in no medical plan enrollment.

County Health Plan Agreement: County Health Plan PPO or County Health Plan EPO

Anthem Blue Cross/Anthem Blue Cross Life and Health Insurance Company Arbitration Agreement

NON-PARTICIPATING PROVIDER: I understand that I am responsible for a greater portion of my medical costs when I use a non-participating provider.

REQUIREMENT FOR BINDING ARBITRATION

ALL DISPUTES BETWEEN YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY, INCLUDING BUT NOT LIMITED TO DISPUTES RELATING TO THE DELIVERY OF SERVICE UNDER THE PLAN/POLICY OR ANY OTHER ISSUES RELATED TO THE PLAN/POLICY AND CLAIMS OF MEDICAL MALPRACTICE, MUST BE RESOLVED BY BINDING ARBITRATION, IF THE AMOUNT IN DISPUTE EXCEEDS THE JURISDICTIONAL LIMIT OF SMALL CLAIMS COURT AND THE DISPUTE CAN BE SUBMITTED TO BINDING ARBITRATION UNDER APPLICABLE FEDERAL AND STATE LAW, INCLUDING BUT NOT LIMITED TO, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT.

California Health and Safety Code Section 1363.1 and Insurance Code Section 10123.19 require specified disclosures in this regard, including the following notice: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as permitted and provided by federal and California law, including but not limited to, the Patient Protection and Affordable Care Act, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

YOU AND ANTHEM BLUE CROSS AND/OR ANTHEM BLUE CROSS LIFE AND HEALTH INSURANCE COMPANY AGREE TO BE BOUND BY THIS ARBITRATION PROVISION. YOU ACKNOWLEDGE THAT FOR DISPUTES THAT ARE SUBJECT TO ARBITRATION UNDER STATE OR FEDERAL LAW THE RIGHT TO A JURY TRIAL, THE RIGHT TO A BENCH TRIAL UNDER CALIFORNIA BUSINESS AND PROFESSIONS CODE SECTION 17200, AND/OR THE RIGHT TO ASSERT AND/OR PARTICIPATE IN A CLASS ACTION ARE ALL WAIVED BY YOU.

Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect on state law. By providing your "wet or electronic" signature below, you acknowledge that such signature is valid and binding.

Employee Signature

Date

Kaiser Permanente Benefit Plan Agreement: Kaiser Permanente HMO, Kaiser Hospital Services Deductible DHMO, or Kaiser Deductible First HDHP

Kaiser Foundation Health Plan Arbitration Agreement

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure or the ERISA claims procedure regulation, and any other claims that cannot be subject to binding arbitration under governing law) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage*.

Signature Required for Kaiser Permanente Plan

Date

Sutter Health Plus Member Agreement: Sutter Health Plus HMO ML42 , Sutter Health Plus Hospital Services Deductible DHMO ML21, or Sutter Health Plus Deductible First HDHP HD01/HD51

BINDING ARBITRATION

Sutter Health Plus handles and resolves member disputes through grievance, appeal and independent medical review processes. However, in the event that a dispute is not resolved in those processes, Sutter Health Plus uses binding arbitration as the final method for resolving all such disputes.

As a condition of your membership in Sutter Health Plus, you agree that any and all disputes between yourself (including any heirs or assigns) and Sutter Health Plus, including claims of medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered), except for small claims court cases and claims subject to ERISA, shall be determined by binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings. You and Sutter Health Plus, including any heirs or assigns to this Agreement, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of binding arbitration.

I hereby agree to give up my/our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the Group Subscriber Contract and *Evidence of Coverage and Disclosure Form*.

Employee Signature

Date

Western Health Advantage Arbitration Agreement: Western Health Advantage HMO, Western Health Advantage Hospital Services DHMO, or Western Health Advantage Deductible First HDHP

Western Health Advantage Arbitration Agreement

By signing below, I acknowledge that I have read, understand and agree to the terms and arbitration agreement stated below. A reproduction of this form shall be valid as an original.

A. On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage offered by Western Health Advantage (WHA) through my Employer, and agree to be bound by the WHA Group Service Agreement, Evidence of Coverage and Disclosure Form, and this Enrollment/Change Form.

B. ARBITRATION AGREEMENT: I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES BETWEEN MYSELF (INCLUDING ANY HEIRS OR ASSIGNS) AND WESTERN HEALTH ADVANTAGE, INCLUDING CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR SMALL CLAIMS COURT CASES AND CLAIMS SUBJECT TO ERISA, SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE PARTIES, INCLUDING ANY HEIRS OR ASSIGNS, TO THIS ARBITRATION AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Employee Signature

Date

Employee Name: _____

Employee ID: _____

Waiver or Declination of Medical Plan Acknowledgment - You must complete this section if you are waiving or declining medical coverage for yourself and/or your eligible dependent(s).

If you wish to waive or decline coverage for yourself or your eligible dependents under County-offered medical plans, you must complete the information below. **To waive medical coverage, the individual must have other group coverage or coverage through Covered CA, otherwise the election is to decline coverage rather than waive.** Continuous coverage in other group insurance is a requirement for mid-year re-enrollment upon the loss of other group coverage or Covered CA.

- Waive Medical Coverage for Myself and any eligible Dependent(s)
- Waive Medical Coverage for my eligible Dependent(s)
- Decline Medical Coverage for Myself and any eligible Dependent(s)
- Decline Medical Coverage for my eligible Dependent(s)

By signing below, I acknowledge that I have been given the opportunity to enroll myself and my eligible dependents in a County-offered medical plan. I understand I will not be eligible to enroll in a County-offered medical plan until the plan's next annual enrollment period or in accordance with the loss of eligibility for other group coverage or coverage through Covered CA. If I become eligible to make a change during the plan year, I must request enrollment within 31 days of the qualifying event.

Employee Signature

Date

Employee Authorization and Signature (Required)

I hereby elect the benefit plan(s) designated on page one of this form. I have also listed my eligible dependent(s) to be added to, or deleted from, the designated benefit plan(s). I also declare under penalty of perjury that all eligible dependents listed above meet the plans' eligibility requirements and all eligible dependents listed as IRS Qualified dependents meet the IRC Section 152 definition of a qualified dependent.

I authorize my employer to deduct from my salary the amount required to cover my share of the premium payment (including any future premium increases). I agree for myself and my dependent(s), effective immediately and for as long as necessary to process claims:

- To be bound by the terms and conditions of the applicable Group Agreement as it may be amended
- To authorize providers who have rendered services to me and my dependent(s) to make health information and records regarding those services available to the health plan and their providers who, in turn, may share such records among themselves.
- To complete and submit consents, releases assignments, and other documents related to protecting the health plan's rights under the Group Agreement. This includes coordinating benefits with other group health plans, insurance policies, Worker's Compensation, or Medicare. I also agree to pay the cost incurred by the health plan out of any awards, settlements, or payments made to me in connection with personal injuries sustained by me or my dependent(s).
- I certify each Social Security number listed on this application is correct.

I understand that I must complete a new **County of Sonoma Employee Benefits Enrollment/Change Form within 31 days** of a change in this qualification or a change of benefit eligibility. I understand that the employee portion of the benefit premiums will be pre-tax only for IRS Qualified dependents. Further, I understand that I am responsible for the tax consequences (including interest and penalties) should there be any misstatement made on this declaration, or even in the absence of a misstatement, should the IRS or the State of California so determine that the benefits I am receiving for dependents listed as Qualified are found to be Non-Qualified.

I also certify that the information provided on this form is complete, true, and correct to the best of my knowledge.

Employee Signature

Date

BENEFICIARY DESIGNATION

Initial Beneficiary Designation(s) OR Change of all prior beneficiary designation(s) (check only one box), I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name	Social Security Number
Employee Address	Telephone Number
Policyholder/Employer County of Sonoma	Policy/Employer Number GL-673199

NAMING THE BENEFICIARY

It is important that your beneficiary designation be clear so that there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, and relationship. If the beneficiary is not related either by blood or marriage, insert the words, "Not Related." On the reverse side of this form you will find examples of common beneficiary designations. If you need assistance, contact your Company representative or your own legal counsel.

PRIMARY BENEFICIARY(IES)			
Name:		Date of Birth:	
Address:			
Social Security Number:	Relationship:	Benefit Percent:	
Check only the coverages applicable to your policy: <input type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental Life <input type="checkbox"/> AD&D <input type="checkbox"/> Supplemental AD&D			
Name:		Date of Birth:	
Address:			
Social Security Number:	Relationship:	Benefit Percent:	
Check only the coverages applicable to your policy: <input type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental Life <input type="checkbox"/> AD&D <input type="checkbox"/> Supplemental AD&D			
Name:		Date of Birth:	
Address:			
Social Security Number:	Relationship:	Benefit Percent:	
Check only the coverages applicable to your policy: <input type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental Life <input type="checkbox"/> AD&D <input type="checkbox"/> Supplemental AD&D			
Name:		Date of Birth:	
Address:			
Social Security Number:	Relationship:	Benefit Percent:	
Check only the coverages applicable to your policy: <input type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental Life <input type="checkbox"/> AD&D <input type="checkbox"/> Supplemental AD&D			

CONTINGENT BENEFICIARY(IES)

Name:		Date of Birth:
Address:		
Social Security Number:	Relationship:	Benefit Percent:
Check only the coverages applicable to your policy: <input type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental Life <input type="checkbox"/> AD&D <input type="checkbox"/> Supplemental AD&D		
Name:		Date of Birth:
Address:		
Social Security Number:	Relationship:	Benefit Percent:
Check only the coverages applicable to your policy: <input type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental Life <input type="checkbox"/> AD&D <input type="checkbox"/> Supplemental AD&D		
Name:		Date of Birth:
Address:		
Social Security Number:	Relationship:	Benefit Percent:
Check only the coverages applicable to your policy: <input type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental Life <input type="checkbox"/> AD&D <input type="checkbox"/> Supplemental AD&D		
Name:		Date of Birth:
Address:		
Social Security Number:	Relationship:	Benefit Percent:
Check only the coverages applicable to your policy: <input type="checkbox"/> Basic Life <input type="checkbox"/> Supplemental Life <input type="checkbox"/> AD&D <input type="checkbox"/> Supplemental AD&D		

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee

Date

EMPLOYER COPY

Following are examples of the most common beneficiary designations:

Mary J. Doe, Wife (not Mrs. John Doe).

Mary J. Doe, Wife, if living, otherwise to Joseph W. Doe, Son.

Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter, and Joseph W. Doe, Son in equal shares, if they are both living, otherwise to whichever of them survive me.

Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the percent of insurance to be paid to each beneficiary, for example "33 1/3% to Mary Jones, Mother and 66 2/3% to Edith Jones, Wife."