**City of Seattle**

**Accidental Death and Dismemberment (AD&D) Insurance Election Form**

(Elections can also be made online at Employee Self-Service)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| Last Name (Please Print) | First Name |  | Employee Number |  | Department |
|  |  |  |  |  |
| Home Address - Street |  | City, State |  | Zip |
|  |  |  |  |  |  |  |
| Hire Date |  | Work Phone |  | Birth Date |  | Social Security Number |

Effective date of coverage/change  for:

 [ ] New employee [ ] Adding supplemental coverage [ ] Canceling supplemental coverage

**[ ] YES,** I am applying for accidental death and dismemberment insurance according to the terms of the group policy issued to the City of Seattle. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance.

**[ ]  Individual** **[ ]  Family Principal Sum $**

**BENEFICIARY:** Specify the *percentage of benefit* for each beneficiary and if any beneficiary is *contingent*. *Contingent* means the person listed only receives the benefit if your named beneficiary is deceased. You are not required to list a contingent beneficiary. If more space is required, please use a separate list, sign, date, and attach to form.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  | % of Benefit |
| Last Name (Please Print) | First Name |  | Address |  | [ ]  Check if Contingent |
|  |  |  |  |  | % of Benefit |
| Last Name  | First Name |  | Address |  | [ ]  Check if Contingent |
|  |  |  |  |  | % of Benefit |
| Last Name  | First Name |  | Address |  | [ ]  Check if Contingent |

 **[ ]  NO,** I do not wish to purchase accidental death and dismemberment coverage at this time. I understand that if I later want coverage, I may only enroll during an open enrollment period.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the insurance company. Penalties include imprisonment, fines and denial of insurance benefits.

|  |
| --- |
| By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge; that I have read and understand the election form and descriptive material covering the options provided under this plan. I authorize the insurance carriers to obtain, examine or release information needed to process claims for myself or my family. |

|  |  |  |
| --- | --- | --- |
| Employee Signature |  | Date |

Send completed form to department benefit’s representative.

|  |  |  |
| --- | --- | --- |
| Department Representative’s signature |  | Date Entered into HRIS |