Seattle
Department of Human Resources

Group Term Life Insurance Enrollment & Change Form

Employee Information: (Please print)

Last Name	First Name	Employee # or last 4-digits of SSN	Birth Date (mm/dd/yyyy)

Basic Group Term Life (GTL) Insurance:

Enrollment Status: (Please select one) Reset this section

◯ New Hire ◯ Change coverage (within 30-day enrollment period) ◯ Decreasing Coverage (mid-year change) ◯ Canceling Coverage (mid-year change)	Life Events (Adding Coverage): ◯ Marriage / Domestic Partnership ◯ Add Dependent Child

Select one option below (A, B or Waive):

◯ **Option A:** Basic group term life insurance **1.5 times** my annual salary.

◯ **Yes**, I am applying for group term life insurance coverage equaling 1.5 times my annual salary. I authorize payroll deductions from my salary for the cost of this insurance based on the coverage amount I select.

◯ **Option B:** Basic group term life insurance **limited coverage** of a flat $50,000

◯ **Yes**, I am applying for Basic GTL coverage limited to $50,000 (instead of the above Basic GTL coverage equal to 1.5 times my annual salary). Previously submitted enrollment information for Basic GTL insurance, excluding current beneficiary information, is superseded by this election. I understand if I later want to increase my GTL coverage amount, I will be required to provide Evidence of Insurability (Medical History Statement).

◯ **Waive Coverage:**

◯ **No**, I do not want to participate in either options of the City of Seattle's group term life insurance plan. I understand that Evidence of Insurability may be required if I want to apply for coverage at a later date.

Supplemental Group Term Life Insurance - Employee:

Reset this section

If you enroll in Basic GTL above, you are eligible to enroll in Supplemental group term life insurance.

Enrollment Status: (Please select one – option on the next page)

◯ New Hire ◯ Change coverage (within 30-day enrollment period) ◯ Decreasing Coverage (mid-year change) ◯ Canceling Coverage (mid-year change)	Life Events* (Adding Coverage): ◯ Marriage / Domestic Partnership ◯ Add Dependent Child *Eligible if employee is enrolled in or electing Basic GTL

Option #1: Employee Supplemental Life Insurance Coverage

◯ **Yes**, I am applying for supplemental GTL insurance for myself. The coverage amount selected does not exceed four times my annual salary rounded to the next lower multiple of $5,000 if not already a multiple of $5,000. I understand the maximum amount of insurance I can receive without Evidence of Insurability when first eligible for the plan is $1,000,000 when combined with Basic GTL. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance. (See calculation example in your Employees Benefits Guide).

Current Annual Salary: $ (hourly rate x 2,088) **x** (up to 4x) **= Coverage Amount: $**

◯ **Yes**, due to a **Life Event**, I am applying for supplemental life insurance or increasing existing supplemental life insurance for myself **up to $50,000**. The resulting amount of insurance does not exceed the guaranteed issue-amount of the lesser of four times annual earnings rounded to the next lower $5,000 if not already a multiple thereof or $1 million (basic and supplemental insurance combined).

Applying for $ (increment of $5,000 not to exceed $50,000)

◯ **No**, I do not want to participate in Employee Supplemental coverage and understand I may be subject to providing Evidence of Insurability to the insurance carrier if I want to enroll at a later date.

Supplemental Group Term Life Insurance – Spouse/Domestic Partner (DP) and Child(ren):

If you enrolled in or are electing **Basic GTL** then you are eligible to enroll in Supplemental Spouse/Domestic Partner and/or Child group term life insurance.

Reset this section

◯ Option #1: Spouse/Domestic Partner Supplemental Life Insurance Coverage

◯ **Yes**, I am applying for supplemental GTL insurance for my spouse/DP in the following amount according to the terms of the group policy issued to the City of Seattle. I understand this coverage can only be purchased if I have also elected **Basic GTL** coverage. The coverage minimum is $5,000 and up to $50,000 is guaranteed issue (amounts elected must be in increments of $5,000). In excess of $50,000 require Evidence of Insurability. The coverage amount is not greater than 100% of my Basic and Supplemental GTL coverage amount combined, up to a maximum of $500,000. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance. (See calculation example in your Benefit Guide)

My Individual Coverage Amount: $ **= Spouse/DP Coverage Amount: $**

◯ **Yes**, due to a **Life Event**, I am applying for supplemental life insurance or increasing existing supplemental life insurance for my spouse or domestic partner by **one increment of $5,000**. I understand the resulting amount is not greater than the guarantee issue amount of $50,000 and this coverage can only be purchased if I am enrolled in or electing **Basic GTL** coverage.

Select coverage amount option: ☐ **$5,000**

◯ Option #2: Dependent Child(ren) Supplemental Life Insurance Coverage

◯ **Yes**, I am applying for supplemental GTL insurance for my child(ren) or my spouse/DP's child(ren) in the amount selected below. I understand this coverage can only be purchased if I have also elected **Basic GTL** coverage. Covered child(ren) must meet the eligibility criteria and benefits for any loss are payable to me. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance. (One amount covers all children.)

Select one coverage amount option: ◯ **$2,000** ◯ **$5,000** ◯ **$10,000**

◯ **Yes**, due to a **Life Event**, I am applying for supplemental life insurance or increasing existing supplemental life insurance for my child(ren).

Select one coverage amount option: ◯ **$2,000** ◯ **$5,000** ◯ **$10,000**

◯ **No**, I do not want to participate in Dependent Child(ren) Supplemental coverage of the City of Seattle's group term life insurance plan.

Evidence of Insurability (Medical History Statement):

Reset this section

Check one of the below boxes to determine whether your coverage amount will be subject to Evidence of Insurability. I have completed and submitted the required Evidence of Insurability* (Medical History Statement) to the insurance company because:

◯ The combined total of my Basic and Supplemental coverage exceeds $1,000,000

◯ The Supplemental coverage for my spouse/DP exceeds $50,000

◯ Open Enrollment: I am applying or increasing coverage during open enrollment

*Complete and submit the Evidence of Insurability online form at www.LifeBenefits.com/SubmitEOI.

- Group policy number: 70467
- Access key: Seattle (case sensitive)

If Evidence of Insurability is required for both you and your spouse/partner, each person must complete their own questions during the same session.

Beneficiary Information:

Reset this section

List the beneficiary(ies) for **your** Basic and Supplemental Group Term Life Insurance coverage. You are the designated beneficiary for any spouse or domestic partner, or dependent child loss. Please specify the percentage of benefit for each beneficiary and if any beneficiary is contingent. Primary beneficiary means the person listed will receive the benefit. Contingent means the person listed only receives the benefit if your named primary beneficiary is unable or unwilling to be a recipient). Your primary and contingent beneficiary percentage amounts must total 100% for each designation. You are not required to list a contingent beneficiary. If more space is needed, use a separate list, sign, date and attach to this form.

Beneficiaries for Basic Group Term Life

			◯ Primary	% of Benefit
			◯ Contingent	% of Benefit
Last Name	First Name	Address		
			◯ Primary	% of Benefit
			◯ Contingent	% of Benefit
Last Name	First Name	Address		
			◯ Primary	% of Benefit
			◯ Contingent	% of Benefit
Last Name	First Name	Address		

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Reset this section

Beneficiaries for Supplemental Group Term Life

Last Name	First Name	Address		
			◯ Primary	% of Benefit
			◯ Contingent	% of Benefit
			◯ Primary	% of Benefit
			◯ Contingent	% of Benefit
			◯ Primary	% of Benefit
			◯ Contingent	% of Benefit

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 may include imprisonment, fines and denial of insurance benefits.

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

Employee's Signature:

Date (mm/dd/yyyy):