**City of Seattle**

**GROUP TERM LIFE INSURANCE ELECTION FORM**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| Last Name (Please Print) | First Name |  | Employee No. |  | Department |
|  |  |  |  |  |
| Home Address - Street |  | City, State |  | Zip |
|  |  |  |  |  |  |  |
| Hire Date |  | Work Phone |  | Birth Date |  | Social Security Number |

**BASIC GROUP TERM LIFE INSURANCE**

 Effective date of coverage/change  for: **[ ]**  New Employee **[ ]** Adding coverage **[ ]**  Canceling coverage

**[ ]  YES**, I am applying for group term life insurance according to the terms of the group policy issued to the City of Seattle, with coverage equaling 1½ times my annual salary. I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance.

**[ ]  NO,** I do not care to participate in the City of Seattle’s group term life insurance plan. I understand that a Medical History Statement will be required if I desire to apply for coverage later during an annual open enrollment period and coverage will be provided at the discretion of the insurance carrier.

|  |
| --- |
|  **BASIC GROUP TERM LIFE INSURANCE -- LIMITED COVERAGE**Effective date of coverage/change  for: **[ ]**  New Employee **[ ]** Adding coverage **[ ]** Canceling coverage  |

**[ ]** My gross salary is greater than $33,000, and I am applying for Basic GTL coverage limited to $50,000 (instead of the above Basic GTL coverage equal to 1½ times my salary) according to the terms of the group policy issued to the City of Seattle. I authorize premiums to be deducted from my 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 Previously submitted enrollment information for Basic GTL insurance, excluding current beneficiary information, is superseded by this election.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 a Medical History Statement. My signed and notarized *Waiver Agreement* accompanies this application.

|  |
| --- |
| **SUPPLEMENTAL GROUP TERM LIFE INSURANCE -- INDIVIDUAL COVERAGE\***Effective date of coverage/change  for: **[ ]**  New employee **[ ]**  Adding coverage  **[ ]**  Canceling coverage **[ ]**  Changing coverage amount |

**[ ]  YES**, I am applying for Supplemental GTL Insurance for myself in the following amount according to the terms of the group policy issued to the City of Seattle. The coverage amount selected below 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 this coverage can only be purchased if I have also elected Basic GTL or Basic GTL - Limited Coverage****.* I authorize deductions from my salary for any contribution I am required to make toward the cost of this insurance.

**Coverage Amount: $       Current Annual Salary: $**

**[ ]  NO**, I do not care to participate in the City of Seattle’s Supplemental GTL plan. I understand that a Medical History Statement will be required if I desire to apply for coverage later during an annual open enrollment period and coverage will be provided at the discretion of the insurance carrier.

|  |
| --- |
| **SPOUSE OR DOMESTIC PARTNER COVERAGE\***Effective date of coverage/change  for: **[ ]**  New employee **[ ]**  Adding coverage  **[ ]**  Canceling coverage **[ ]**  Changing coverage amount |

**[ ]  YES**, I am applying for Supplemental GTL Insurance for my spouse/domestic partner in the amount of **$**  according to the terms of the group policy issued to the City of Seattle. **This coverage amount is at least $5,000 or a multiple of $5,000, and is *not greater* than 50% of my Individual Supplemental GTL coverage amount.** I understand this coverage can only be purchased if I have also elected Individual Supplemental GTL coverage, and benefits for any loss are payable to me. I authorize deductions from my salary for contributions I am required to make toward the cost of this insurance.

**[ ]  NO**, I do not care to select the City of Seattle’s Supplemental GTL insurance plan for a spouse/partner. I understand that if I currently have a spouse/partner, s/he will be required to submit a Medical History Statement if I desire to apply for coverage later during an open enrollment period. Coverage will be provided at the discretion of the insurance carrier.

|  |
| --- |
| **DEPENDENT CHILD COVERAGE\***Effective date of coverage/change  for: **[ ]**  New employee **[ ]**  Adding coverage  **[ ]**  Canceling coverage **[ ]**  Changing coverage amount |

**[ ]  YES**, I am applying for Supplemental GTL Insurance for my child(ren) or my spouse’s/domestic partner’s child(ren) in the amount selected below 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 Individual Supplemental 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)

 **[ ]  $2,000 [ ]  $5,000 [ ]  $10,000**

**[ ]  NO**, I do not care to select the City of Seattle’s Supplemental GTL insurance plan for dependent children. I understand that if I currently have a dependent child(ren), I may apply for coverage later only during an annual open enrollment period.

|  |
| --- |
| **BENEFICIARY INFORMATION**Effective date of beneficiary change  |

List the beneficiary(ies) for *your* Basic and Supplemental Group Term Life Insurance. (You are the designated beneficiary for any spouse or partner, or dependent child loss.) Please 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, use a separate list, sign, date and attach to this form.

-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

 **Beneficiaries for Basic Group Term Life**

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

**------------------------------------------------------------------------------------------------------------------------------------------------------------------------**

 **Beneficiaries for Supplemental Group Term Life**

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

-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

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 carrier to obtain, examine or release information needed to process claims for myself or my family. |

Employee’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I have completed and mailed the required Medical History Statement to the insurance company because:**

**[ ]** I am not a new employee and I am applying during open enrollment.

[ ]  I am not a new employee and I am applying for Spouse or Domestic Partner coverage during open enrollment.

[ ]  I am a new employee and the combined total of my Basic and Supplemental coverage exceeds $1,000,000.

[ ]  I am a new employee and the Supplemental coverage for my spouse/domestic partner exceeds $50,000.

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

*Revised March 2017* \*Temporary benefited employees (TBE) are not eligible for Supplemental, Spouse/DP, and Child GTL Coverage.