OPEN ENROLLMENT 2020 SUPPLEMENTAL TERM LIFE INSURANCE ENROLLMENT

Reliastar Life Insurance Company, Minneapolis, MN
Telephone: 800-955-7736
A member of the Voya® family of companies.

EFFECTIVE DATE:
RECEIVED BY:
ENTRY DATE: ENTERED BY:

OPEN ENROLLMENT SUPPLEMENTAL TERM LIFE INSURANCE ENROLLMENT FORMS DUE TO HUMAN RESOURCES EMPLOYEE BENEFITS DIVISION BY NOVEMBER 8, 2019.

Email: HRBenefits@fresnocountyca.gov **Phone:** (559) 600 - 1810 **Fax:** (559) 455 - 4787

Address: 2220 Tulare Street, 14th Floor, Fresno, CA 93721 **Website:** www.co.fresno.ca.us/openenrollment

EMPLOYEE INFORMATION: *Complete all information.*

Name (First, Middle Initial, Last):________________ Employee ID: ________

SSN: ________ DOB: ________ Phone Number: ________

Address:________________ City:________ State:____ ZIP:______

EMPLOYEE SUPPLEMENTAL LIFE INSURANCE ELECTION:

Benefit amount(s) are based on the employee's age band and reduce to 65% of original coverage at age 65, to 50% of original coverage at age 70, to 25% of original coverage at age 75, and to 20% of original coverage at age 80 and after. Your payroll deductions will be adjusted to pay premiums based on the new benefit amount(s). Please note that spouse and/or child(ren) coverage requires employee enrollment to elect.

❑ **Elect $100,000 Employee Coverage (or reduced amount based on age).**

EMPLOYEE SUPPLEMENTAL LIFE INSURANCE POLICY BENEFICIARY:

Designate your beneficiaries below. Primary beneficiary percentages must total 100% and contingent beneficiary percentages must total 100%. Percentages must be whole numbers (i.e. 33, 33, 34). If additional space is required, please attach a separate signed and dated document with the same information for each beneficiary as is detailed below.

❑ **Primary** ❑ **Contingent** **Percentage:** 0%

Name (First, Middle Initial, Last):________________ DOB: ________ ❑ M / ❑ F

Address:________________ City:________ State:____ ZIP:______

Phone:________ SSN: ________ Relationship: ________

❑ **Primary** ❑ **Contingent** **Percentage:** 0%

Name (First, Middle Initial, Last):________________ DOB: ________ ❑ M / ❑ F

Address:________________ City:________ State:____ ZIP:______

Phone:________ SSN: ________ Relationship: ________

❑ **Primary** ❑ **Contingent** **Percentage:** 0%

Name (First, Middle Initial, Last):________________ DOB: ________ ❑ M / ❑ F

Address:________________ City:________ State:____ ZIP:______

Phone:________ SSN: ________ Relationship: ________

FORM CONTINUED ON NEXT PAGE

SPOUSE LIFE INSURANCE ELECTION:

Employee coverage must be elected before adding spouse coverage. The use of "spouse" in this form means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the plan. Please contact the Employee Benefits office for more information.

Benefit amounts are based on the employee's age band and reduce to 65% of the original coverage at age 65, to 50% of original coverage at age 70, to 25% of original coverage at age 75, and to 20% of original coverage at age 80 and after. Employee coverage must be elected before adding spouse coverage. A spouse is not eligible for life insurance if they are a current County of Fresno employee and are eligible to enroll in employee coverage.

Note: The employee is the beneficiary for any spouse insurance coverage.

❑ **Elect $50,000 Spouse Coverage (or reduced amount based on employee's age).** ❑ **Decline Spouse Coverage**

SPOUSE INFORMATION: *Required if electing Spouse Coverage.*

Name (First, Middle Initial, Last):_____ ❑ M / ❑ F

Phone:_____ SSN: _____ DOB: _____

CHILD(REN) LIFE INSURANCE ELECTION:

Employee coverage must be elected before adding child(ren) coverage. Children are eligible from ages 0-26. The premium cost for child(ren) includes all eligible children. Children are not eligible if they are a current County of Fresno employee and are eligible to enroll in employee coverage.

Note: The employee is the beneficiary for any child(ren) insurance coverage.

❑ **Elect $10,000 Child Coverage (for each eligible child).** ❑ **Decline Child Coverage**

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW:

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by Reliastar Life Insurance Company, provided I am actively at work.
- I also understand that I am required to submit evidence of insurability to ReliaStar Life Insurance Company, and they will determine if I am eligible to enroll.

X SIGNATURE: _____ DATE: _____

By signing above, I authorize the enrollment of the above listed elections.

PLAN INFORMATION: PLAN INFORMATION SECTION TO BE COMPLETED BY THE EMPLOYER/PLAN SPONSOR.

All new Life coverage will require evidence of insurability. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

Employer/Plan Sponsor Name: County of Fresno Group/Plan Number: 70833-0 Account Number/Location: 001

Employment Status: ❑ Active Full-Time ❑ Active Part-Time Effective Date of Coverage or Change: _____

EMPLOYEE BENEFITS PERSONNEL USE ONLY.

Evidence of Insurability Provided: _____ **AdminDirect Entry Date:** _____

Evidence of Insurability Approved: _____ **AdminDirect Entry by:** _____