

City of Rockledge ENROLLMENT FORM

Group Life Insurance products provided by UnitedHealthcare Insurance Company

Use this form to apply or make changes to the coverages listed below.
Late applicants are subject to Evidence of Insurability.

A. EMPLOYEE INFORMATION

| | | | | | | | | |
|---|--|------------|-----------------------|------|------------------------|-----------|--|---------------|
| <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Address Change <input type="checkbox"/> Name Change <input type="checkbox"/> Other | | | | | Date | | | |
| Last Name | | First Name | | M.I. | Social Security Number | | Gender <input type="checkbox"/> M <input type="checkbox"/> F | Date of Birth |
| Street Address | | | Apt No. | City | State | Zip Code | County | |
| Home Phone () | | | Work Phone () | | Date of Hire | | <input type="checkbox"/> Single <input type="checkbox"/> Married | |
| Employer or Group Name | | | Division/Location | | Subgroup Code | Job Title | Salary | |

B. PRODUCT SECTION - Application for (check all that apply):

| <input type="checkbox"/> Supplemental Employee Life \$ _____ benefit amount \$25,000 to \$150,000 in increments of \$25,000 <input type="checkbox"/> Supplemental Dependent Life option 1 \$20,000 Spouse benefit and \$10,000 child (ren) benefit (age 15 days to 6 months is \$1,000) <input type="checkbox"/> Supplemental Dependent Life option 2 \$10,000 Spouse benefit and \$5,000 child (ren) benefit (age 15 days to 6 months is a \$500 benefit) | Beneficiary Designation: Life coverage <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="width: 33%;">Primary Beneficiary</th> <th style="width: 33%;">Percentage</th> <th style="width: 33%;">Relationship to Insured</th> </tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr> <th>Contingent Beneficiary</th> <th>Percentage</th> <th>Relationship to Insured</th> </tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </table> <p>Additional Beneficiaries should be listed on the back of this form. The employee is automatically the beneficiary for the dependent coverage.</p> | Primary Beneficiary | Percentage | Relationship to Insured | | | | | | | | | | Contingent Beneficiary | Percentage | Relationship to Insured | | | | | | |
|--|--|-------------------------|------------|-------------------------|--|--|--|--|--|--|--|--|--|------------------------|------------|-------------------------|--|--|--|--|--|--|
| Primary Beneficiary | Percentage | Relationship to Insured | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
| Contingent Beneficiary | Percentage | Relationship to Insured | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | | | |
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C. INFORMATION FOR DEPENDENT COVERAGE (if applicable)

| Last name | First Name | M.I. | Date of Birth | Relationship | If child is over age 19, please indicate status and/or school | Gender | Check one |
|-----------|------------|------|---------------|--------------|---|--|---|
| | | | | | <input type="checkbox"/> Handicapped <input type="checkbox"/> Student at | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Waive <input type="checkbox"/> Change |
| | | | | | <input type="checkbox"/> Handicapped <input type="checkbox"/> Student at | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Waive <input type="checkbox"/> Change |
| | | | | | <input type="checkbox"/> Handicapped <input type="checkbox"/> Student at | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Waive <input type="checkbox"/> Change |
| | | | | | <input type="checkbox"/> Handicapped <input type="checkbox"/> Student at | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Waive <input type="checkbox"/> Change |
| | | | | | <input type="checkbox"/> Handicapped <input type="checkbox"/> Student at | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="checkbox"/> Enroll <input type="checkbox"/> Cancel <input type="checkbox"/> Waive <input type="checkbox"/> Change |

D. SIGNATURE (THIS FORM MUST BE SIGNED)

I understand that by signing this form that I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected.

X _____
Signature

_____ Date

E. EMPLOYER USE ONLY

| | | | |
|---|--------------------------------------|------------------------|--------------|
| <input type="checkbox"/> Initial enrollment following Date of Hire <input type="checkbox"/> Late Applicant | Employee Effective Date (mm/dd/yyyy) | Signed for Employer by | Group Number |
|---|--------------------------------------|------------------------|--------------|

