Life Insurance Enrollment/Change Form

Employee Name:_____ Employee ID:_____

Department _____ Date of Birth: _____/_____/_____ ☐SEIU / LIUNA ☐Other

Employee Election ☐Add Coverage ☐Increase/Decrease Coverage ☐Cancel Coverage ☐Beneficiary Change Only

Election Event ☑ One	Election Event Date	Election Amount *Select multiples of $10,000 up to $600,000(SEIU/LIUNA employees are limited to 7x annual salary rounded down to the nearest 10,000 increment.)*
☐New Hire/Re-Hire	/ /	**$_____ Election amount above Guaranteed Issue EOI Required**
☐Newly Eligible	/ /	**$_____ Election amount above Guaranteed Issue EOI Required**
☐Late Entrant	/ /	**$_____ EOI Required**
☐Open Enrollment Election		**$_____ EOI Required**
☐Open Enrollment Increase	**From $_____ to $_____**	***You may increase one increment of 10K without EOI for Supplemental Life Only***
☐Reduce Coverage	From $_____to $_____	
Coverage will be added, increased, reduce or cancelled the first day of the month following receipt of your request.		

Beneficiary Designation (If you require additional space for beneficiary designations, attach additional sheet.)

Basic Life Beneficiary					
Primary-Name	**Social Security**	**Date of Birth**	**Phone**	**Relationship**	**% of Benefit**
1)					
Address					
2)					
Address					
				Total must equal 100% of benefit	**100%**
Contingent-Name	**Social Security**	**Date of Birth**	**Phone**	**Relationship**	**% of Benefit**
1)					
Address					
2)					

Address		
	Total must equal 100% of benefit	**100%**

Employee Name:_____ Employee ID:_____

Supplemental Life Beneficiary

☐ **Check here if same as the Basic Life Beneficiary**

Primary-Name	**Social Security**	**Date of Birth**	**Phone**	**Relationship**	**% of Benefit**
1)					
Address					
2)					
Address					
				Total must equal 100% of benefit	**100%**
Contingent-Name	**Social Security**	**Date of Birth**	**Phone**	**Relationship**	**% of Benefit**
1)					
Address					
2)					
Address					
				Total must equal 100% of benefit	**100%**

Legal Spouse/Registered Domestic Partner Election

☐ **Add Coverage** ☐ **Increase/Decrease Coverage** ☐ **Cancel Coverage**

Your Legal Spouse or Registered Domestic Partner is eligible for coverage. It is your responsibility to cancel coverage if you divorce, terminate your Domestic Partnership or if your Spouse or Registered Domestic Partner decease. You are automatically designated as the Beneficiary for this coverage.

Spouse/Domestic Partner Name:_____ Date of Birth: _____/____/_____

Date of Marriage/Divorce/ Death_____/_____/_____ Social Security Number: _____-_____-_____

(Circle One)

☐ New Election Amount: $_____ *Select multiples of $5,000 up to $100,000/ Election amount above Guaranteed Issue EOI Required*

☐ Open Enrollment Increase From $_____ to $_____ *You may increase one increment of 5K without EOI*

☐ Reduce Coverage From $_____ to $_____

Dependent Life (Child Rider) ☐Add Coverage ☐Increase/Decrease Coverage ☐Cancel Coverage

This election covers all eligible children under age 26 (See Benefits Guide for additional dependent eligibility requirements.). It is your responsibility to terminate this coverage election when you no longer have eligible children. You are automatically designated as the Beneficiary for this coverage.

Election Amount ☐$5,000 or ☐$10,000

Employee Name:_____ Employee ID:_____

Authorization

I authorize the County of Riverside to make payroll deductions to cover the cost for Supplemental (Voluntary) Life Insurance coverage(s) I have elected and understand that it is my responsibility to request cancellation of dependent coverage when my dependents no longer meet eligibility requirements. I understand that benefits are not provided for ineligible dependents. Claims will not be paid for a dependent who does not meet the plan eligibility requirements at the time of claim. I further understand that I forfeit a refund of premiums paid for an ineligible dependent unless I have properly notified the County of the dependent's status change and requested cancellation of their coverage within 60 days of the dependent's loss of eligibility.

NOTE:

- Amounts of coverage elected above the Guarantee Issue amount are subject to ***medical underwriting approval (EOI).*** To submit a medical history statement online, visit: http://www.standard.com/mybenefits/mhs_ho.html .
- All late applications (applying 60 days after becoming eligible), requests for coverage increases and reinstatements are subject to medical underwriting approval (EOI). Employees eligible but not insured under the prior life insurance plan are also subject to medical underwriting approval.
- The coverage amount for your spouse cannot exceed 100 % of your combined Basic and Additional Live coverage.
- The coverage amount for your child(ren) cannot exceed 100 % of your combined Basic and Additional Live coverage.

Employee Signature:_____ Date:_____/_____/_____

Please submit your completed form to:

*** Your Riverside County Human Resources Department Representative**

*** Mail Stop: 1150**

*** Or email to Benefits@rivco.org**