# CITY OF IRVING LIFE / AD&D INSURANCE ENROLLMENT / CHANGE FORM

## SECTION 1 GENERAL INFORMATION

| *EMPLOYEE* | | | | |
|---|---|---|---|---|
| Name (Last) (First) (M.I.) | | | | Social Security # |
| Address (City) (State) (ZIP Code) (County) | | | | |
| Home Phone ( ) | Dept. # | Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed | | Sex ☐ Female ☐ Male |

**EFFECTIVE DATE OF ENROLLMENT / CHANGE:**

### *OPTION CODE LIST*

*Enter appropriate code in tables below for each enrollment / change*

**E** = Enroll / add dependent

**T** = Terminate coverage / drop dependent

**C** = Convert to new plan or coverage level

### *LIFE INSURANCE AND AD&D COVERAGE LEVEL OPTIONS*

***FOR DETAILS REGARDING ELIGIBILITY AND PREMIUMS, PLEASE REFER TO YOUR ENROLLMENT INFORMATION PACKET.***

**Employee Life/AD&D**: Option to PURCHASE 1x, 2x, 3x, 4x or 5x annual base salary. (City provides 1x annual base salary $_____.)

**Spouse Life/AD&D**: Maximum $100,000 or 50% of employee's combined benefit, whichever is *less (see SPD for more information). Coverage in increments of $10,000. Coverage in excess of $50,000 requires an EOI.*

**Child Life/AD&D**: Maximum $15,000 for eligible dependent child(ren) age 14 days to 26 years.

## SECTION 2 SELECTION LIFE/AD&D INSURANCE BENEFITS

Complete Section 2 across the page, providing information *only* where enrollment/change applies. Life and AD&D are a combined benefit.

*Line numbers below correspond to:*
*Line 1: Employee (if not applicable, leave line blank)*
*Line 2: Spouse (if not applicable, leave line blank)*
*Lines 3-7: Eligible dependents*

**ENTER CHOICES BELOW**
**A Employee Optional Life/AD&D**
Enter 1x, 2x, 3x, 4x or 5x
**B Spouse Optional Life/AD&D**
Enter dollar amount ÷ 1000
**C Dependent Children Life/AD&D**
Check (✓) all to be covered

**PERSON(S) TO BE ENROLLED OR AFFECTED BY CHANGE(S)**

| | Name | Social Security | Birth Date | Sex | Relationship | | Option (see list) | A | B | C |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Employee: | | | | Self | 1 | | | | |
| 2 | Spouse: | | | | Spouse | 2 | | | | |
| 3 | Dependent: | | | | | 3 | | | | |
| 4 | Dependent: | | | | | 4 | | | | |
| 5 | Dependent: | | | | | 5 | | | | |
| 6 | Dependent: | | | | | 6 | | | | |
| 7 | Dependent: | | | | | 7 | | | | |

Employee's Signature _____ Date _____

# Group Life and AD&D Insurance Beneficiary Designation Form

Employee Name _____

Social Security No. _____ Department No. _____

I hereby designate the individual (s) shown below as my beneficiary (i.e.) insurance benefits. Any benefits that may be payable, upon my death, should be paid as designated below. Where two or more contingent (alternate) beneficiaries are designated, benefits will be paid equally to all of the contingent beneficiaries. If you choose to name a minor as your beneficiary, court appointed legal guardianship is required for the guardian to gain access to life insurance proceeds. Otherwise, proceeds will remain in an account designated for the minor until the minor reaches age of majority.

## Basic Group Term Life Insurance and Accidental Death & Dismemberment Insurance

- Provided by City of Irving to all regular full-time employees.

**PRIMARY (CAN BE MORE THAN ONE): IN EQUAL PARTS**

| Name | Relationship | Social Security # | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**CONTINGENT (CAN BE MORE THAN ONE): IN EQUAL PARTS**

| | Name | Relationship | Social Security # | Date of Birth |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |

## Optional Life and Accidental Death & Dismemberment Insurance

-Purchased by employee

**PRIMARY (CAN BE MORE THAN ONE): IN EQUAL PARTS**

| Name | Relationship | Social Security # | Date of Birth |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**CONTINGENT (CAN BE MORE THAN ONE) IN EQUAL PARTS**

| | Name | Relationship | Social Security # | Date of Birth |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |

Should the beneficiary(ies) named above become deceased before me and I fail to name another, then this designation shall become inoperative and it is understood that any benefits payable shall be paid to my estate.

Employee's Signature _____ Date _____