# Life and Accidental Death & Dismemberment (AD&D) Insurance Enrollment/Change Form

## SECTION 1: AGENCY/POLICY HOLDER INFORMATION *Personnel, payroll, or benefits office completes this section.*

| Employing agency | | Policyholder name/number<br>**Washington State Health Care Authority/123731** | Agency/subagency code |
|---|---|---|---|
| **Employee's hire date** | **Employee's gross annual salary** | ❑ **Full-time employee**<br>❑ **Part-time employee** | **Effective date of coverage or change in coverage** |

## SECTION 2: EMPLOYEE INFORMATION *Employee completes this section.*

| Social Security number | Name (last, first, middle initial) | Date of birth (mm/dd/yyyy) | Employee I.D. number |
|---|---|---|---|
| Street address (include city, state, ZIP Code) | | | ❑ Female<br>❑ Male |
| Mailing address (include city, state, ZIP Code)—if different from above | | Work phone number | Home phone number |

Have you used tobacco products of any kind, other than for ceremonial or religious reasons, in the last 2 months? ❑ Yes ❑ No

Has your spouse/registered domestic partner used tobacco products of any kind, other than for ceremonial or religious reasons, in the last 2 months? ❑ Yes ❑ No

Are you a retiree returning to work? ❑ Yes ❑ No

If yes, and you were enrolled in PEBB retiree term life insurance, do you want to keep retiree term life insurance while you're employed? (Cost is $7.75 per month.) ❑ Yes ❑ No

Type of request *(check all that apply)*:

- ❑ New hire (newly eligible)
- ❑ Request to cover spouse/registered domestic partner*
- ❑ Request to cover child(ren)
- ❑ Return from leave of absence
- ❑ Transfer of coverage from spouse/registered domestic partner PEBB life insurance coverage*
- ❑ Late entrant (person requesting coverage after initial eligibility)
- ❑ Request to remove spouse/registered domestic partner from coverage
- ❑ Request to remove child(ren) from coverage
- ❑ Request to change coverage amounts after initial eligibility
- ❑ Request to cancel all life and AD&D insurance coverage (except Basic Life Insurance and Basic AD&D Insurance for employee)

**within 60 days of marriage or registered domestic partnership, or within 31 days of spouse's/registered domestic partner's loss of other PEBB life insurance*

The term "registered domestic partner" is defined as: a) effective January 1, 2010, a state-registered domestic partner; or b) a domestic partner who was qualified under PEBB eligibility criteria as a domestic partner before January 1, 2010, and was continuously enrolled under the employee in a PEBB health insurance plan or life insurance.

## SECTION 3: EMPLOYEE LIFE INSURANCE *Employee completes this section. See "Premium Rates" on the PEBB website at http://www.hca.wa.gov/pebb/pages/rates_life.aspx to determine your estimated monthly costs.*

| | I am requesting the coverage below (enter or check your selections): |
|---|---|
| **Basic Life and Basic Accidental Death & Dismemberment (AD&D) Insurance** ***for Employee***<br>Paid by your employer, except if you are on Leave Without Pay. | ☑ $25,000 Basic Life Insurance<br>$5,000 Basic AD&D Insurance |
| **Supplemental Life Insurance** ***for Employee***<br>You may apply for $10,000 to $750,000 of Employee Supplemental Life Insurance (in $10,000 increments).<br>When you are newly eligible for Employee Supplemental Life Insurance:<br>• If you are less than age 60, you can elect up to $250,000 without evidence of insurability.<br>• If you are age 60 or over, you can elect up to $100,000 without evidence of insurability.<br>At all other times or to request higher coverage amounts, you must complete a *Life Insurance Evidence of Insurability* form, to be approved by ReliaStar Life. | A. Total amount desired $________<br>This is the total amount of coverage you want.<br>B. Current amount $________<br>If you do not currently have coverage, enter $0.<br>C. Guaranteed issue amount $________<br>Newly eligible employees can elect up to $250,000 (if under age 60) without evidence of insurability, or $100,000 (if age 60 or over). If you are not a newly eligible employee, enter $0.<br>D. Amount requiring evidence of insurability (A) - (B) - (C) = (D) $________<br>❑ Cancel this coverage |

*continued*

## SECTION 4: SPOUSE/REGISTERED DOMESTIC PARTNER/DEPENDENT LIFE INSURANCE

*Employee completes this section (only needed if you are enrolling your dependent(s) in basic and/or supplemental life insurance).*

| Spouse name (last, first, middle initial) | Spouse date of birth (mm/dd/yyyy) | Spouse Social Security number | Date of marriage/registration of partnership |
|---|---|---|---|
| | | | |

| | I am requesting the coverage below (enter or check your selections): |
|---|---|
| **Basic Life Insurance** ***for Spouse/Registered Domestic Partner and Children***<br>You must have Employee Supplemental Life Insurance and Basic Life Insurance for your spouse/registered domestic partner to apply for Supplemental Life Insurance for your spouse/registered domestic partner. | ❑ Apply for coverage for my spouse/registered domestic partner--$2,500 life insurance<br>❑ Keep coverage for my spouse/registered domestic partner--$2,500 life insurance<br>❑ Apply for coverage for my children--$2,500 life insurance per child<br>❑ Keep coverage for my children--$2,500 life insurance per child<br>❑ Cancel spouse/registered domestic partner's coverage<br>❑ Cancel children's coverage |
| **Supplemental Life Insurance** ***for Spouse/Registered Domestic Partner***<br>If you have Employee Supplemental Life Insurance and Basic Life Insurance for your spouse/registered domestic partner, you may apply for Supplemental Life Insurance for your eligible spouse/registered domestic partner. You may apply for up to 50% of the amount of your Employee Supplemental Life Insurance, in $5,000 increments.<br>When you or your spouse/registered domestic partner is newly eligible for Supplemental Life Insurance, you can elect up to $50,000 without evidence of insurability.<br>At all other times or to request higher coverage amounts, you must complete a *Life Insurance Evidence of Insurability* form for your spouse/registered domestic partner, to be approved by ReliaStar Life. | **You must have Employee Supplemental Life Insurance and Spouse/Registered Domestic Partner Basic Life Insurance to apply for Spouse/Registered Domestic Partner Supplemental Life Insurance.**<br>A. Total amount desired $____________________<br>This is the total amount of coverage you want. This coverage cannot exceed 50% of the Employee Supplemental Life Insurance amount.<br>B. Current amount $____________________<br>If you do not currently have coverage, enter $0.<br>C. Guaranteed issue amount $____________________<br>Newly eligible employees or newly eligible spouses/registered domestic partners can elect up to $50,000 (not to exceed 50% of the Employee Supplemental Life Insurance amount) without evidence of insurability. If you are not a newly eligible employee or spouse/ registered domestic partner, enter $0.<br>D. Amount requiring evidence of insurability (A) - (B) - (C) = (D) $____________________<br>❑ Cancel this coverage |

## SECTION 5: SUPPLEMENTAL AD&D INSURANCE *Employee completes this section.*

| | I am requesting the coverage below (check your selections): |
|---|---|
| **Supplemental Accidental Death & Dismemberment (AD&D) Insurance** ***for Employee***<br>You may apply for $25,000 to $250,000 of Employee Supplemental AD&D Insurance (in $25,000 increments). | ❑ Employee Supplemental AD&D Insurance in the amount of $____________________ *(in $25,000 increments, up to $250,000)*<br>❑ Cancel this coverage |
| **Supplemental Accidental Death & Dismemberment (AD&D) Insurance** ***for Dependents***<br>You must have Employee Supplemental AD&D Insurance to apply for Dependent Supplemental AD&D Insurance. | ❑ Include this coverage for my dependents.<br>❑ **Do not** include coverage for my dependents.<br>❑ Cancel this coverage. |

## SECTION 6: BENEFICIARIES *Employee completes this section. Attach a list of other beneficiaries if needed (signed and dated).*

| Name of beneficiary (last, first, middle initial) | ☑ Primary | Relationship to employee | Date of birth (mm/dd/yyyy) |
|---|---|---|---|
| Address (include city, state, ZIP Code) | Benefit % | Social Security number | Phone number |
| Name of beneficiary (last, first, middle initial) | ❑ Primary<br>❑ Secondary | Relationship to employee | Date of birth (mm/dd/yyyy) |
| Address (include city, state, ZIP Code) | Benefit % | Social Security number | Phone number |

## SECTION 7: SIGNATURE *Employee completes this section.*

By signing this form I declare that the information I have provided is true, complete, and correct. **I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.** In addition, I understand that I and my dependents must follow eligibility and procedural criteria established by the Policyholder. I authorize my employer to deduct premiums for supplemental coverage from my paycheck. I understand that coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work. I also understand that ReliaStar Life may require evidence of insurability for coverage to be effective. This form replaces all previous forms and submissions I have made for PEBB life insurance. The information collected about you is confidential. We will not release any information about you without your authorization, except to conduct our business or as required or permitted by law.

**Employee's signature** ____________________________________________ **Date** ____________________

***Return this form to your personnel, payroll, or benefits office.***