



Internal Services Agency

Department of Personnel Services

Employee Benefits Office

AnnMarie Meyer, Manager

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## County of Sacramento

### LIFE INSURANCE ENROLLMENT/CHANGE FORM

Employee Name \_\_\_\_\_ SSN \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

DOB \_\_\_\_\_ Date of Hire \_\_\_\_\_ Marital Status \_\_\_\_\_

**Optional Coverage**  New Enrollment  Change Option

Enroll  Cancel Option A (1 X annualized salary to \$50,000 max)

Enroll  Cancel Option B (1 X annualized salary to \$500,000 max, plus County paid Basic)

Enroll  Cancel Option C (2 X annualized salary to \$500,000 max, plus County paid Basic)

Enroll  Cancel Option D (3 X annualized salary to \$500,000 max, plus County paid Basic)

#### Beneficiary Information

Name and Address	Relationship	Date of Birth (If under 18)	Percentage
			%
			%
			%
			%
Trustee for minor child	Address	Phone	

#### Dependent Enrollment (Bargaining Units 005 & 008 Only)

Spouse/DP Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Child Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Child Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Child Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

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 that any person who knowingly and with intent to defraud, submits an application or files a claim containing any materially false or misleading information, commits a fraudulent act, which is a crime.** I understand my coverage begins on the effective date assigned, provided I am actively at work.

\_\_\_\_\_  
**Employee Signature**

\_\_\_\_\_  
**Date**

Reviewed By		Date	
Basic Coverage <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$18,000 <input type="checkbox"/> \$50,000	Effective Date	Optional Coverage	Effective Date