

Employee Life Insurance Enrollment Form

INSTRUCTIONS: Top box to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. All new life coverage or any increases in life coverage will require proof of good health if plan participation requirements are not met. Any references to coverage being obtained without proof of good health in the sections below are only applicable if the plan participation requirements are met.

Name of Employer/Plan Sponsor County of Kern		Group/Plan Number 630322	Account Number/Location 002	
State of Employee's Primary Worksite:	Class/Occupation	Date of Hire (mm/dd/yyyy)	Annual Salary	Employment Status: ☐ Active Full-Time ☐ Active Part-Time
This change is due to: (check all that apply) ☐ Initial Eligibility Following Hire ☐ Change in Coverage Amount			☐ Add Dependent Coverage ☐ Late Entrant* ☐ Other: _____	
				Effective Date of Coverage or Change:

*A late entrant is an individual who is first enrolling for coverage after the first available opportunity.

Employee Information

Employee Name (last, first, middle initial)		Date of Birth (mm/dd/yyyy)	Social Security #	Employee I.D. #
Employee Address (street address, city, state, zip code)		Work Phone Number	Home Phone Number	☐ Female ☐ Male

Employee Life Insurance

Portable Life	Guaranteed Issue (GI) Limit = \$200,000. When you are first eligible for Portable Life coverage, you can elect up to the GI Limit without proof of good health. Total Portable Life coverage up to \$500,000 is available if you complete a Portable Proof of Good Health form subject to approval by ReliaStar Life.
Portable Life Election	I currently have Portable Life coverage of: \$ _____. I am applying for additional Portable Life coverage of: \$ _____. (\$10,000 increments) Total Portable Life coverage (current plus additional): \$ _____. ☐ Waive

Beneficiary Information Designate your beneficiary(ies) below.

Name of Beneficiary (last name, first, middle initial)	☒ Primary	Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Name of Beneficiary (last name, first, middle initial)	☐ Primary	☐ Contingent	Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number	

Name of Beneficiary (last name, first, middle initial)	☐ Primary	☐ Contingent	Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number	

Dependent Life Insurance

Dependent Child(ren) Life Insurance	Either you or your spouse/domestic partner may cover your dependent child(ren), but not both. When you are initially eligible for dependent coverage, you can elect it without proof of good health. At all other times, a Portable Proof of Good Health form must be completed for your child(ren) subject to approval by ReliaStar Life.
Dependent Child(ren) Life Insurance Election	☐ \$10,000 for each eligible dependent child. (\$1,000 for children age 14 days to 6 months of age) ☐ Waive

Note: The employee is the beneficiary for any Dependent insurance coverage elected on this form.

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- 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 my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee's Signature	Date Signed (mm/dd/yyyy)
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Please return completed forms within 60 days of your hire date

Kern County Health & Wellness

1115 Truxtun Ave, 1st Flr, Bakersfield, CA 93301

Need additional information or assistance contact us at (661) 868-3182