Please print clearly and mark carefully.

Employer Name: **City of Springfield**	Effective Date:_____
PLEASE CHECK APPROPRIATE BOX : ❑ New Enrollment ❑ Add/Remove Dependents ❑ Cancel Coverage ❑ Information Change ❑ Change Coverage Amount	

About You: First, MI, Last Name		Social Security Number _ _ _ - _ _ - _ _ _ _	
Address	City	State	Zip
Gender: ❑ M ❑ F	Date of Birth:_____	Phone:	
Email Address:			

About Your Job:	Hours worked per week: _____	Job Title:
Employment Status: ❑ Active ❑ Retired Employee ID #:	Hire Date: ____ - ____ - ____	Annual Salary: $_____

About Your Family: Please include the names of the dependents you wish to enroll for coverage. A dependent is a person that you, as a taxpayer, claim; who relies on you for financial support; and for whom you qualify for a dependency tax exception. Dependency tax exemptions are subject to IRS rules and regulations. Additional information may be required for non-standard dependents such as a grandchild, a niece or a nephew.

Spouse (First, MI, Last Name) Address/City/State/Zip: Phone:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____
Child/Dependent 1: Address/City/State/Zip: Phone:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____
Child/Dependent 2: Address/City/State/Zip: Phone:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____
Child/Dependent 3: Address/City/State/Zip: Phone:	❑ Add ❑ Drop	Gender ❑ M ❑ F	Social Security Number ____ - ____ - ____ Date of Birth (mm-dd-yyyy) ____ - ____ - ____

Cancel Coverage:

❑ Cancel Employee ❑ Cancel Dependents

The date of cancellation cannot be prior to the date this form is completed and signed.

Last Day of Coverage: _____-_____-_____

❑ Termination of Employment ❑ Retirement

Last Day Worked: _____-_____-_____

❑ Other Event: _____

Date of Event: _____-_____-_____

Coverage Being Cancelled:

❑ Basic Life

❑ Voluntary Life ❑ Employee ❑ Spouse ❑ Child(ren)

Basic Life Coverage:

Policy Amount ❑ $5,000

Employee Only ❑ I do not want this coverage.

Beneficiary Information to be provided in another section.

Voluntary Term Life Coverage With Accidental Death and Dismemberment (AD&D):

You must be enrolled to cover your dependents.

Employee Guaranteed Issue Amounts *Check one (1) box only*

Ages 18-54	Ages 55-69	Ages 70+
❑ $150,000	❑ $80,000	❑ $10,000

❑ I do not want this coverage.

Spouse Voluntary Life Guaranteed Issue Amounts *Check one (1) box only*

Ages 18-54 ❑ $50,000 Ages 55-69 ❑ $30,000 Ages 70+ ❑ N/A

❑ I do not want this coverage.

Child Voluntary Life Guaranteed Issue Amounts *Check one (1) box only*

Ages 14 days-1 year ❑ $1,000 Ages 1-19 ❑ $10,000

Important Notes:

- Based on your plan benefits and age, you may be required to complete an evidence of insurability form for Voluntary Life.

Name your beneficiaries: (Primary beneficiary percentages must total 100%) If electing different beneficiaries that are not the same as those named for Basic Life, please name below.

Primary Beneficiaries:

Name: **Social Security Number:**___ ___ ___-___ ___-___ ___ ___ ___ **Percentage%** _____

Date of Birth (mm-dd-yy):___-___-___ **Address/City/State/Zip:** _____

Phone: **Relationship to Employee:** _____

Name: **Social Security Number:**___ ___ ___-___ ___-___ ___ ___ ___ **Percentage%** _____

Date of Birth (mm-dd-yy):___-___-___ **Address/City/State/Zip:** _____

Contingent Beneficiary: **Relationship to Employee:** _____

Name: **Social Security Number:**___ ___ ___-___ ___-___ ___ ___ ___

Date of Birth (mm-dd-yy):___-___-___ **Address/City/State/Zip:**

Phone: **Relationship to Employee:** _____

(In the event the primary beneficiaries are deceased, the contingent beneficiary will receive the benefit. Employer maintains beneficiary information.)

Health History

Complete the following question(s) if you are enrolling for one or more of the following benefits listed below. NOTE: Additional information may be required.

Voluntary Life

In the last 6 months have you or any of your dependents received medical care, including treatment, consultation services, diagnostic measures or monitoring of a condition in remission; or taken prescribed drugs for: Cancer, Heart Disease, Diabetes; any condition related to Acquired Immune Deficiency Disorder (AIDS) or AIDS Related Complex; or any other Chronic Condition?

❑ Yes, I have. ❑ No, I haven't. ❑ Yes, my spouse has. ❑ No, my spouse hasn't. ❑ Yes, my dependent child(ren) have. ❑ No, my dependent child(ren) haven't.

An Evidence of Insurability form must be completed for any person with a "Yes" answer to the question(s) above.

Signature

- I understand that life insurance coverage for a dependent, other than a newborn child, will not take effect if that dependent is confined to a hospital or other health care facility, or is home confined, or is unable to perform the normal activities of someone of like age and sex.
- I understand that my dependent(s) cannot be enrolled for a coverage if I am not enrolled for that coverage.
- I understand that the premium amounts shown above are estimations and are for illustrative purposes only.
- Submission of this form does not guarantee coverage. Among other things, coverage is contingent upon underwriting approval and meeting the applicable eligibility requirements as set forth in the applicable benefit booklet.
- I understand that I must be actively at work or my elected coverage will not take effect until I have met the eligibility requirements (as defined in the benefit booklet.) This does not apply to eligible retirees.
- If coverage is waived and you later decide to enroll, late entrant penalties may apply. You may also have to provide, at your own expense, proof of each person's insurability.
- Plan design limitations and exclusions may apply. For complete details of coverage, please refer to your benefit booklet. State limitations may apply.
- Your coverage will not be effective until approved by a the insurance company or its designated underwriter.
- I hereby apply for the group benefit(s) that I have chosen above.
- I understand that I must meet eligibility requirements for all coverages that I have chosen above.
- I agree that my employer may deduct premiums from my pay if they are required for the coverage I have chosen above.
- I acknowledge and consent to receiving electronic copies of applicable insurance related documents, in lieu of paper copies, to the extent permitted by applicable law. I may change this election only by providing thirty (30) day prior written notice.
- **I attest that the information provided above is true and correct to the best of my knowledge.**
- "Caution: If you answers on this application are incorrect or untrue, the insurance company has the right to deny benefits or rescind your policy."

Any person who with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information or conceals for purpose of misleading information concerning any fact material hereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

The state in which you reside may have a specific state fraud warning. Please refer to the attached Fraud Warning Statements page.

The laws of New Yorkrequire the following statement appear: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. (Does not apply to Life Insurance.)

SIGNATURE OF EMPLOYEE X _____ **DATE** _____

Fraud Warning Statements

The laws of several states require the following statements to appear on the enrollment form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penal ties.

California: For your protection California law requires the following to appear on this form: The falsity of any statement in the application shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policy holder or claimant for the purpose of defrauding or attempting to defraud the policy holder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.