

To Be Completed By Human Resources

Group Number 330823	Division	Billing Category	Date of Employment
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To Be Completed By Applicant Apply for Coverage Beneficiary Change *Complete Beneficiary Section below.* Name Change
 Add or Delete Dependent Date of add/delete _____

Your Name (Last, First, Middle)	Your Social Security Number	Birth Date	<input type="checkbox"/> Male <input type="checkbox"/> Female
Your Address		City	State ZIP
Former Name (Last, First, Middle) <i>Complete only if name change</i>		Phone Number	
Employer Name City of Tumwater		Job Title/Occupation	
Hours Worked Per Week	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> Week <input type="checkbox"/> Month <input type="checkbox"/> Year		

Coverage Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.

Life Insurance

Life with AD&D (Employer Paid)

Supplemental Life Insurance

Supplemental Life Your requested amount \$ _____ Spouse requested amount \$ _____

Dependents Life Insurance

Spouse Life Requested amount \$ _____

Spouse Name _____ Date of Birth _____

Child(ren) Life Requested amount \$ _____

Beneficiary *This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. Unless specified otherwise on a separate sheet of paper, this designation will also apply to Supplemental Life and Accidental Death and Dismemberment (AD&D) Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.*

Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit
Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit

Signature I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.

Member/Employee Signature Required _____ Date (Mo/Day/Yr) _____