Fulton County, Georgia

revised 09/2020

Group Life Insurance Enrollment Form

EMPLOYEE NAME LAST **FIRST** **MIDDLE INITIAL** **SEX** **DATE OF BIRTH**

DATE OF HIRE (FULL TIME) **SOCIAL SECURITY NUMBER** **DEPARTMENT**

Coverage Selection:

_____	**Basic Life Coverage**	**$50,000**	**$1.56 per mo**
_____	**Supplemental Life**	_____**(Coverage Amount)** (Cannot exceed 300,000)	**$7.50 per $25,000 per mo**
_____	**Dependent Life**	**$10,000 per dependent**	**$1.08 per mo**

Eligible Dependents:

DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER

BENEFICIARY DESIGNATION: If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage).

FIRST NAME LAST NAME	SOCIAL SECURITY #	RELATIONSHIP & ADDRESS	BENEFIT %
Primary			
Primary			
Contingent			
Contingent			

I HEREBY REQUEST TO BE INSURED AND AUTHORIZE DEDUCTIONS, IF ANY, FROM MY COMPENSATION FOR MY SHARE OF THE COST OF THE BENFITS TO WHICH I MAY BE ENTITLED UNDER THE GROUP POLICY (IES) ISSUED TO THE EMPLOYER LISTED ABOVE. I UNDERSTAND THAT IF I AM NOT ACTIVELY AT WORK AS DEFINED IN THE POLICY ON THE DATE MY COVERAGE WOULD OTHERWISE BECOME EFFECTIVE, MY INSURANCE WILL NOT BEGIN UNTIL THE DAY I MEET THE POLICY DEFINITION OF ACTIVELY AT WORK. FOR THOSE COVERAGES I HAVE DECLINED, I UNDERSTAND THAT IF I CHOOSE TO ENROLL AT A LATER DATE, MY COST MAY BE HIGHER AND A HEALTH QUESTIONNARIRE MAY BE REQUIRED. I UNDERSTAND THAT ANY INDIVIDUAL DEPENDENT CAN ONLY BE COVERED ONCE IN THIS GROUP LIFE INSURANCE PLAN.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a 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 subjects such person to criminal and civil penalties.

EMPLOYEE SIGNATURE_____ DATE_____/_____/_____

Please return completed form via
Email: employeebenefits@fultoncountyga.gov
Fax: (404) 612-3675