



# CARROLLTON TEXAS

This enrollment form is for actively at work employees to apply for **Supplemental Life Insurance** for employee, spouse and child(ren) (Beneficiary Designation for Basic Life Coverage is also included on this form). In order to elect Supplemental Life Insurance for a spouse or child, you (the employee) must have Supplemental Life Insurance in place for yourself. Supplemental Life insurance is administered by The Standard.

## SECTION I - APPLICANT INFORMATION

Name: First, Middle Initial, Last		SSN		Date of Hire	
Date of Birth	Gender (M or F)	Daytime Phone Number ( )	Evening Phone Number ( )		
Home Address: Number and Street			City	State	Zip Code
Occupation			Annual Salary		

## SECTION II – SUPPLEMENTAL LIFE BENEFIT ELECTION

**\*\*If you are electing Life coverage over the Guarantee Issue amount (\$400,000 basic and supplemental combined) OR, you are enrolling after your initial enrollment period, you MUST complete a Medical History Statement and your coverage will not go into effect unless your application is approved by The Standard. Workforce Services will forward you a Medical History Statement upon receipt of this form. You must mail the completed Medical History Statement to The Standard for review.**

<b>Check the boxes that apply:</b>		
<b>ACCEPT</b>	<b>WAIVE*</b>	<b>Election Amount</b>
<input type="checkbox"/>	<input type="checkbox"/>	Life – Employee Coverage (1 or 2 times salary to a max of \$400,000; employee must enroll in order to purchase spouse or dependent coverage)
<input type="checkbox"/>	<input type="checkbox"/>	Life – Spouse Coverage (Minimum of \$5,000 and increments of \$5,000 up to the lesser \$100,00 or 100% of the employee's election)
<input type="checkbox"/>	<input type="checkbox"/>	Life – Child Coverage (Benefit reduced to \$250 for children ages 0 – 6 months)
		<b>\$5,000</b>
<p>*My signature below certifies that I have been given the opportunity to participate in the City of Carrollton Employee benefit program. The benefits have been clearly explained to me. After careful consideration I have decided not to participate in the benefits listed above where I have checked "waive". I understand that if I later decide to apply for coverage under this plan I may be required to furnish evidence of insurability.</p>		
Signature _____		Date _____

## SECTION III – DEPENDENT INFORMATION

<b>Spouse Name:</b> First, Middle Initial, Last	Sex	Date of Birth	Benefit Amount
<b>Child Name:</b> First, Middle Initial, Last	Sex	Date of Birth	Benefit Amount
<b>Child Name:</b> First, Middle Initial, Last	Sex	Date of Birth	Benefit Amount
<b>Child Name:</b> First, Middle Initial, Last	Sex	Date of Birth	Benefit Amount

(PLEASE CONTINUE on the back)

