To Be Completed By Human Resources

Group Number	Division	Billing Category	Date of Employment
160407			

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	☐ Male ☐ Female

Your Address	City	State	ZIP

Former Name (Last, First, Middle) *Complete only if name change*	Phone Number

Employer Name	Job Title/Occupation
City of Blackfoot	

Hours Worked Per Week	Earnings $__________ Per: ☐ Hour ☐ Week ☐ Month ☐ Year

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

Life Insurance

☒ Basic Life with AD&D (Employer Paid)

You may choose one of the following options for yourself:

☐ Additional Life requested amount $__________ **OR** ☐ Additional Life with AD&D requested amount $__________

Dependents Life Insurance

☐ Spouse Life $10,000 / Child(ren) Life $10,000 (Employer Paid)

You may choose one of the following options for your spouse:

☐ Spouse Life requested amount $__________ **OR** ☐ Spouse Life with AD&D requested amount $__________

You may choose one of the following options for your child(ren):

☐ Child(ren) Life $10,000 **OR** ☐ Child(ren) Life with AD&D $10,000

Short Term Disability ☒ Employer Paid STD

Dental

☐ Voluntary Dental

Coverage requested for ☐ You, your Spouse & Children ☐ You & your Spouse ☐ You only ☐ You & your Children (no Spouse)

Are you covered for dental insurance under another plan? ☐ Yes ☐ No Are one or more dependents? ☐ Yes ☐ No

List dependents to enroll or delete for Dental, if applicable (Attach sheet for additional dependents, if needed).

Spouse Full Name	☐ Male ☐ Female	Birth Date
Child 1 Full Name	☐ Male ☐ Female	Birth Date
Child 2 Full Name	☐ Male ☐ Female	Birth Date
Child 3 Full Name	☐ Male ☐ Female	Birth Date

Dental Insurance Waiver: Contributory Dental Insurance

The insurance coverage available to me and my dependents has been explained to me and I do not want to enroll at this time. I understand that if I elect to enroll in the future, the insurance coverage may be subject to a Late Enrollment Penalty.

I decline ☐ Dental insurance for myself. I decline ☐ Dental insurance for one or more dependents.

Beneficiary ***This designation applies to Life/Life with 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) ______________

Return completed form to your Human Resources Department.