Group Life Insurance Enrollment

THE STANDARD

EMPLOYER NAME: Frederick County Public Schools

Return completed and signed form to your Benefits Office.

☐ **New Enrollment** ☐ **Name Change** ☐ **Beneficiary Change** ☐ **Retiree**

EMPLOYEE INFORMATION (Mandatory)				
First Name		Middle Initial	Last Name	
Street Address		City	State	Zip Code
Date of Birth	Social Security #	Job Title/Occupation	Date of Employment	Gender ☐ Male ☐ Female

MY BENEFICIARY DESIGNATION

PRIMARY BENEFICIARY(IES) (Mandatory) *All money shall be paid in equal shares to the primary beneficiary(ies) who are living at the time of death.*			
First Name		Middle Initial	Last Name
Date of Birth	Social Security #	Gender ☐ Male ☐ Female	Relationship
First Name		Middle Initial	Last Name
Date of Birth	Social Security #	Gender ☐ Male ☐ Female	Relationship

CONTINGENT BENEFICIARY(IES) *If all primary beneficiaries die before me all money shall be paid in equal shares to the following person(s) who are living at the time of my death.*			
First Name		Middle Initial	Last Name
Date of Birth	Social Security #	Gender ☐ Male ☐ Female	Relationship
First Name		Middle Initial	Last Name
Date of Birth	Social Security #	Gender ☐ Male ☐ Female	Relationship

OPTIONAL DEPENDENT LIFE

Cost: $10.80/Year Coverage: Spouse-$4,000/Child(ren) $2,000 (under the age of 19).

☐ Yes ☐ No

SPOUSE INFORMATION		
First Name	Middle Initial	Last Name
Date of Birth	Social Security #	Gender ☐ Male ☐ Female

CHILD(REN)		
First Name	Middle Initial	Last Name
Date of Birth	Social Security #	Gender ☐ Male ☐ Female
First Name	Middle Initial	Last Name
Date of Birth	Social Security #	Gender ☐ Male ☐ Female

AUTHORIZATION			
I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for supplemental insurance coverage. I understand that all insurance coverage becomes effective according to the terms of the contract.			
Employee Signature	Daytime Telephone Number	Evening Telephone Number	Date Signed