



Williamson County Employer Paid Term Life Insurance \$40,000

FOR EMPLOYEE TO COMPLETE

Department or work location _____

Employee Name _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex: Male Female Date of Employment _____ Date of Birth _____

VOLUNTARY DEPENDENT COVERAGE ELECTIONS

Amount of coverage selected for:

You have the opportunity to elect basic life insurance for your dependent(s). You may elect coverage for your spouse in the amount of **\$5,000** and **\$2,500** for each of your child (ren) between the ages of 15 days & 26 years.

Basic Dependent Life

Spouse \$5,000

Child (ren) \$2,500

I elect to enroll my spouse and/or child(ren) in the supplemental life plan at a monthly cost of .63 per family unit

SPOUSE M/F SOCIAL SECURITY # _____ DATE OF BIRTH _____

CHILD M/F SOCIAL SECURITY # _____ DATE OF BIRTH _____

CHILD M/F SOCIAL SECURITY # _____ DATE OF BIRTH _____

I decline the supplemental life plan for my spouse or child(ren)

NOTE: If you have chosen coverage over the Guarantee Issue amount for you or your spouse, you will also need to complete an Evidence of Insurability form. The amount of coverage over your Guarantee Issue amount will be subject to medical underwriting approval. If you DO NOT APPLY FOR coverage for you or your dependent(s) during the 31-DAY initial enrollment period, you will need to complete an Evidence of Insurability form for all amounts of coverage.

BENEFICIARY DESIGNATION:

	Full Name	Address	SSN	Relationship	D.O.B.	%
Primary						
Contingent						

REQUEST FOR SIGNATURE

Please read the back of this form carefully before signing below.

CERTIFICATION: I certify that all statements are true to the best of my knowledge and belief and I understand that a copy of this form will be made available at my request. I have read and understand the INFORMATION ABOUT DELAYED EFFECTIVE DATES and EXCLUSIONS on the reverse side of this enrollment form. I authorize my employer to make the necessary deductions from my salary or wages to pay the premium when my insurance becomes effective. I understand that my payroll deduction amount will change if my coverage or costs change.

Employee Signature Date

cell or home phone number

Limitations and Exclusions

DELAYED EFFECTIVE DATE

Employee:

Insurance will be delayed for employees not in active employment until the first of the month, coincident with or next, following the date they return to work. Regularly scheduled vacation time is considered active employment.

Dependents:

Coverage for totally disabled dependents will be delayed until the first of the month, coincident with or next, following the date the individual is no longer totally disabled. This delay does not apply to newborn children while dependent insurance is in effect.

Dependents Only:

EXCLUSION FOR SUICIDE

Where the cause of death is suicide:

1. No benefits will be payable for a loss occurring within 24 months after the individual's initial effective date of insurance; and
2. No increased or additional insurance will be payable for a loss occurring within 24 months after the day such increased or additional insurance is effective.