## Life & Disability Insurance Benefit Enrollment Form Return to: <u>benefitforms@stlouiscountymn.gov</u> by internal email only





eturn to: <u>benefitforms@stlouiscountymn.gov</u> by intern	ial email only			S E	RVICES
Employer Name: St. Louis County			Ν	IIS Group Number: 0123	24
Full Name (Last name, First name, Middle Initial):			Ľ	Date of Hire/Date status o	hanged to Full time:
Home Address:		City:		State:	Zip:
Employee ID #: (required)	□ Single □ Married		itizen? ⊵s □ No	Date of Birth:	□ Male □ Female
Occupation/Title:	Select One: St Lo	uis County 🗆	ARC 🗆 CH	lВ	□ 37.5 hrs/wk □ 40.0 hrs/wk
Basic Life (You MUST Select ONE):	Elect  Decline	No Change			
Long Term Disability Insurance (You Mi	UST Select ONE):			<b>ity Insurance (You</b> cel □ No Change	MUST Select ONE):
Employee Supplemental Life (You MU					
□ Elect \$ C	hoose \$10,000 incremen	ts up to \$500,0	000 or six tim	es your annual salary,	whichever is less.
□ Decline/Cancel □ Increase by \$ or □	Decrease by \$	C	haase \$10.00	0 increments only	
$\Box$ No Change	Decred3e by φ	0	10030 010,00	o moremento only.	
				Tip: Unless y	our spouse is newly
Spousal Supplemental Life (You MUS	T Select ONE):			eliaihle and y	ou are electing
□ Elect \$ Choose has elected.	\$5,000 increments up to	half of the am	ount employe	e \$30,000 or le	ess in coverage on
				your spouse,	, he/she will need to
□ Increase by \$ or □	Decrease by \$	(	Choose \$5.00	submit EOI (	
increments only.		``	5110000 \$0,00	mouruomey,	also known as the stionnaire and await
🗆 No Change				approval.	
Not Applicable, not married					
Spouse's Name		Spouse's	Date of Birth	Date o	of Marriage
Child Supplemental Life (You MUST S	elect ONE):				
□ Elect □ \$10,000 □ \$15,000 □ \$2	0 000				
□ Increase/Decrease from \$	to 🗆 \$10,000 🗆	□\$15,000 □	3\$20,000 in	coverage	
□ No Change				0	
Not Applicable, no children					
Child's Name					T Student? 🗆 Y 🗆 N
Child's Name					
Child's Name					
Child's Name	- to for any statistic and the	Child's	Date of Birth	F	T Student? □ Y □ N
□ I have more children and have attached a she Is your covered spouse or any covered ch					
For all elections made above, Medical Quest				-	
are electing more than the Guarantee Is					
I have been given the opportunity to apply for gro	oup insurance and agree	to accept or o	lecline cover	age(s) as noted above	e. If I am declining
coverage(s), I understand that if my dependents					
be required at my own expense and the insurance employer to make any required deductions, if any					
effective. Warning: Any person who knowingly p					
fines, confinement in prison, and/or denial of insu					
Signature:			Date:		

List the person(s) entitled to rece			
Primary Beneficiary(ies) Attach additiona	l pages if necessary.		
Full Name:		Relationship to you:	% of Benefit
Full Name:		Relationship to you:	% of Benefit
Full Name:		Relationship to you:	% of Benefit
Secondary Beneficiary(ies) Attach addition	onal pages if necessary.		
Full Name:		Relationship to you:	% of Benefit
ull Name:		Relationship to you:	% of Benefit
Full Name:		Relationship to you:	% of Benefit
such a designation.) Spouse's Name:	<b>e</b> : (		
·	Signature:		Date:
Sign Here Signature:	Signature:	Date:	Date:
Sign Here	Coverag	e Amount \$	
Sign Here Signature: For Employer Use Only: Annual Salary \$	Coverag	e Amount \$	
Sign Here Signature: For Employer Use Only: Annual Salary \$ Coverage Effective date or Eligibility Date	Coverag	e Amount \$	
Sign Here Signature: For Employer Use Only: Annual Salary \$ Coverage Effective date or Eligibility Date For Employer Use Only:	Coverag	e Amount \$	