



Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

MINNESOTA LIFE
Life Insurance and AD&D Enrollment Form
County of San Bernardino Policy Number 33772 & 33773

Must print in Black or Blue ink ONLY

Table with 3 columns: Employee ID, Last Name, First Name, Department; Date of Hire, Date of Birth, Age

Voluntary Life Insurance - Employee [] Before-Tax [] After-Tax

You have the opportunity to re-enroll or enroll for the first time in the County of San Bernardino's Voluntary Life Insurance plan. You may elect coverage in increments of \$10,000, subject to a maximum of \$700,000.

[] I elect to enroll or re-enroll in the Voluntary Life Plan. *Total amount of voluntary term life insurance requested \$ _____

[] I elect to decline the Voluntary Life Plan.

*Note: Benefit reductions begin at age 70. If you are over the age of 70, the bi-weekly costs shown are calculated based on your reduced benefit amount, not the employee life amount shown.

Voluntary Life Insurance - Spouse/Domestic Partner (offered on after-tax basis only)

You can enroll your spouse or registered domestic partner in the Voluntary Life Insurance plan. You may elect coverage in increment of \$10,000, subject to a maximum of \$250,000.

[] I elect to enroll or re-enroll in the Voluntary Spouse/Domestic Partner Life Plan. **Total amount of voluntary term life insurance requested \$ _____

[] I elect to decline the Voluntary Spouse/Domestic Partner Life Plan.

Table with 4 columns: Spouse/Domestic Partner Last Name, First Name, SSN, Relationship, Date of Birth

**Note: Benefit reductions also applies on Spouse/Domestic Partner coverage.

Voluntary Life Insurance - Child(ren) (offered on after-tax basis only)

You can enroll your eligible child(ren) under the age of 26 in the Voluntary Life Insurance plan. You may elect coverage in increment of \$5,000, subject to a maximum of \$20,000.

[] I elect to enroll or re-enroll in the Voluntary Child(ren) Life Plan. ***Total amount of voluntary term life insurance requested \$ _____

[] I elect to decline the Voluntary Child(ren) Life Plan.

Table with 4 columns: Child(ren) Last Name, First Name, SSN, Relationship, Date of Birth

***Note: One election will cover all eligible child(ren).

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New Hire- EMACS-HR (0030)

Mid-Year- HR-EBSD (0440)

Voluntary Accidental Death & Dismemberment (AD&D) Before-Tax After-Tax

Plan Option	Employee	Spouse or Domestic Partner	Each Child
1	\$10,000	\$5,000	\$3,125
2	\$25,000	\$12,500	\$6,250
3	\$50,000	\$25,000	\$12,500
4	\$100,000	\$50,000	\$25,000
5	\$150,000	\$75,000	\$25,000
6	\$200,000	\$100,000	\$25,000
7	\$250,000	\$125,000	\$25,000

AD&D is offered to all units except Fire Fighters, Per Diem Nurses, Safety and Safety Management and certain contract positions.

 I elect to **enroll** in the Voluntary AD&D plan. Refer to the current Employee Benefits Guide to determine your bi-weekly cost for this coverage.Select a plan option: Option 1 Option 2 Option 3 Option 4 Option 5 Option 6 Option 7**Select one of the following coverages:** EMPLOYEE ONLY FAMILY I elect to **decline** the Voluntary AD&D plan..**Beneficiary Designation**

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship, date of birth and distribution percentage. Contingent beneficiaries collect only if all primary beneficiaries predecease the insured. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example, "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

	Full Name	Address	SSN	Relationship	Date of Birth	%
Primary						
Contingent						

*A beneficiary for employee Life Insurance may be changed upon written request***Employee Confirmation**

I have been given the opportunity to enroll in the County of San Bernardino's Group Voluntary Life & AD&D Insurance plans with Minnesota Life. I understand that for any amount which exceeds the guarantee issue amount, I will be required to provide evidence of good health that is satisfactory to Minnesota Life and understand my request for coverage may be denied. I authorize my employer to make the appropriate payroll deductions from my wages. I am not now disabled and I am performing all the duties of my occupation on a full-time basis.

Employee Signature	Date

FOR OFFICE USE ONLY

EOI Required	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse/Domestic Partner
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FOR HR USE ONLY

Processed By (Employee ID)	Date

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REV HR 05/25/2017

(Life Insurance and AD&D Enrollment - Minnesota Life)