VOYA FINANCIAL™

Voluntary Group Term Life and Dependent Life Insurance Enrollment/Change Form

Employer Use Only

Employee ID:
Effective Date:
Processed By:

EMPLOYEE INSTRUCTIONS: *Please complete ALL sections of this enrollment form and return the completed form to your Employer/Plan Sponsor.*

Name of Employer/Plan Sponsor **Shelby County Government**		**Group/Plan Number** **67848-1**	**Account Number/Location** **0001 – All Eligibles**
Class/Occupation	**Date of Hire** *(mm/dd/yyyy)*	**Annual Salary**	**Employment Status:** ☐ Active Full-Time ☐ Active Part-Time
This change is due to: *(check all that apply)* ☐ New Hire ☐ Late Entrant* ☐ Change in Coverage Amount ☐ Other: _____			**Effective Date of Coverage or Change:**

**A late entrant is an individual who is first enrolling for supplemental or dependent coverage after the first available opportunity.*

Employee Information

Employee Name *(last, first, middle initial)*	Date of Birth *(mm/dd/yyyy)*	Social Security #	Employee I.D. #
Employee Address *(street address, city, state, zip code)*	Work Phone Number	Home Phone Number	☐ Female ☐ Male

Employee Life Insurance

Basic Life	Guaranteed Issue (GI) Limit: 2 times annual salary to a maximum of $350,000 ☑ Employee Only

Basic Life Insurance

Beneficiary Information: *Designate your beneficiary(ies) below.*

Name of Beneficiary *(last name, first, middle initial)* ☐ Primary		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number
Name of Beneficiary *(last name, first, middle initial)* ☐ Primary		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number
Name of Beneficiary *(last name, first, middle initial)* ☐ Primary		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number
Name of Beneficiary *(last name, first, middle initial)* ☐ Contingent		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number
Name of Beneficiary *(last name, first, middle initial)* ☐ Contingent		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Employee Life Insurance

Voluntary Life	Guaranteed Issue (GI) Limit = $150,000. When you are first eligible for voluntary life coverage, you can elect up to the GI Limit without evidence of insurability. At all other times you must provide evidence of insurability subject to approval by ReliaStar Life Insurance Company, a member of the ING family of companies. Total voluntary life coverage up to $400,000 is available if you complete an Evidence of Insurability form subject to approval by ReliaStar Life Insurance Company, a member of the ING family of companies.
Voluntary Life Election	I am applying for voluntary life coverage in the amount of: ☐ $10,000 ☐ $25,000 ☐ $50,000 ☐ $100,000 ☐ $150,000 ☐ Cancel Coverage ☐ $200,000 ☐ $250,000 ☐ $300,000 ☐ $350,000 ☐ $400,000

Voluntary Life

Beneficiary Information *Designate your beneficiary(ies) below.*

Name of Beneficiary *(last name, first, middle initial)* ☐ Primary ☐ Contingent		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Name of Beneficiary *(last name, first, middle initial)* ☐ Primary		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Name of Beneficiary *(last name, first, middle initial)* ☐ Contingent		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Name of Beneficiary *(last name, first, middle initial)* ☐ Contingent		Relationship to Employee	Benefit %
Address	Date of Birth	Social Security Number	Phone Number

Dependent Life Insurance

Dependent Life	Guaranteed Issue (GI) Limit = $30,000 for your Spouse; $15,000 for your Children. When you are initially eligible for dependent coverage, you can elect it without evidence of insurability. At all other times you must provide evidence of insurability on your spouse subject to approval by ReliaStar Life Insurance Company, a member of the ING family of companies. Eligible Children are those at birth but less than age 19; unmarried, full-time student dependents age 19 years but less than age 25.
Dependent Life Election	I am applying for dependent life coverage in the amount of: ☐ Option 1: $20,000 Spouse/$10,000 Child ☐ Option 2: $15,000 Spouse/$7,500 Child ☐ Option 3: $10,000 Spouse/$5,000 Child ☐ Option 4: $5,000 Spouse/$5,000 Child ☐ Option 5: $25,000 Spouse/$12,500 Child ☐ Option 6: $30,000 Spouse/$15,000 Child ☐ Cancel Coverage

Note: The employee is the beneficiary for any Dependent insurance coverage.

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Employee's Signature	Date Signed *(mm/dd/yyyy)*