

Check all box(es) and complete all sections that apply. Return completed form to your Human Resources Department.

MEMBER INFORMATION	Enrollment		Change	
	<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> Add Dependent	<input type="checkbox"/> Delete Dependent	<input type="checkbox"/> Date of add/delete _____
	<input type="checkbox"/> Rehire/Reinstatement	<input type="checkbox"/> Beneficiary Change	<input type="checkbox"/> Address Change	<input type="checkbox"/> Name Change <input type="checkbox"/> Other _____
	Group Name City of Riverside		Group Number 641996	
	Your Name (Last, First, Middle)		If Name Change, What Was Your Former Name?	
	Your Address		City	
Date Of Birth		<input type="checkbox"/> Male <input type="checkbox"/> Female		
Date Of Full-time Hire		Hours Worked Per Week		
Earnings \$		Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr		
Job Title/Occupation		State		
Division ID		ZIP		
Soc. Sec. No.				

COVERAGE SECTION	<i>Check with your Human Resources Department about coverage options, Dependent eligibility, and Evidence Of Insurability requirements.</i>			
	1. Basic Life and AD&D Insurance is provided at no cost for eligible members.			
	2. Additional Life Insurance Members Additional Group Life is a choice of increments of \$10,000. From \$10,000 to \$300,000.			
	<input type="checkbox"/> Additional Life Employee requested amount \$ _____			
	❖ If you elect a coverage amount greater than \$100,000 , then medical underwriting approval is required regardless of when you apply.			
	❖ ALL application requests for coverage outside the 30 day window of an employee's hire or promotion date requires medical underwriting approval.			
	3. Additional Life Insurance Spouse Additional Group Life is available only if the Member elects Additional Life. Choice of \$5,000 increments from \$5,000 to \$150,000 maximum. Coverage may not exceed 100% of the Member Additional Life amount.			
<input type="checkbox"/> Spouse requested amount \$ _____ Spouse Name _____ Date of Birth _____				
❖ If you elect a coverage amount for your spouse greater than \$50,000 , then medical underwriting approval is required regardless of when you apply.				
❖ ALL application requests for spousal coverage outside the 30 day window of an employee's hire or promotion date requires medical underwriting approval.				
4. Additional Life Child(ren) Additional Group Life is available only if the Member elects Additional Life. Children Additional Group Life is available for dependent children from live birth through age 25. Coverage may not exceed 100% of the Member Additional Life amount.				
I elect Children coverage <input type="checkbox"/> \$ 2,000 of coverage <input type="checkbox"/> \$ 5, 000 of coverage <input type="checkbox"/> \$ 10,000 of coverage				
❖ ALL requests for dependent coverage outside the 30 day window of an employee's hire or promotion date requires medical underwriting approval.				
5. Long Term Disability Members of IBEW Local 47				
<input checked="" type="checkbox"/>				
6. Contributory Long Term Disability Executive Non-represented Members				
<input type="checkbox"/> I Elect				
7. Long Term Disability Management employees representing the General Unit, or Public Utilities Field Unit, City Council members, Police Chief & Fire Chief, who participate in the Deferred Compensation Plan.				
<input type="checkbox"/> I Elect – Premiums paid through your Deferred Compensation Plan.				

BENEFICIARY	<i>This designation applies to Coverage Section 1 coverage above. Unless specified otherwise on a separate sheet of paper, this Designation will also apply to Coverage Section 2. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further beneficiary information.</i>				
	Primary – Full Name		Address		Soc. Sec. No.
	Relationship		%		Benefit
	Contingent – Full Name		Address		Soc. Sec. No.
Relationship		%		Benefit	

SIGNATURE	I wish to apply for insurance under the Group Insurance Plan, or to authorize the changes noted above. I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.	
	Member Signature Required	Date (Mo/Day/Yr)

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
 1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
 2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
 3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.

Human Resources Department – Retain for your records.