Employee Application

Return completed form to your group's Benefits Department

☐ Initial Enrollment ☐ Change

City of St Peter

Life Insurance

Employee Information

EMPLOYER				POLICY NUMBER	UNIT
EMPLOYEE NAME (LAST, FIRST, MIDDLE INITIAL)			DATE OF EMPLOYMENT	SOCIAL SECURITY NUMBER	
STREET ADDRESS			CITY	STATE	ZIP CODE
DATE OF BIRTH (Mo, Day, Yr)	ANNUAL SALARY	☐ MALE ☐ FEMALE	MARRIAGE DATE	EMAIL ADDRESS	
BUSINESS PHONE	HOME PHONE		# OF HOURS WORKED PER WEEK		
SPOUSE NAME (LAST, FIRST, MIDDLE INITIAL)				SPOUSE SOCIAL SECURITY NUMBER	
DATE OF BIRTH (MONTH, DAY, YEAR)			EMAIL ADDRESS		

Life Insurance Benefits

Maximum for Optional Life Insurance:
$300,000 for Employee, $150,000 for Spouse, and Child Life

	Class(if applicable)	Amount	Effective Date
Basic Employee Life Insurance	_____	$_____	_____

	Present Amount	Increase/Decrease	Grand Total	Effective Date
Employee Optional Life Insurance	$_____	$_____	$_____	_____
Spouse Optional Life Insurance	$_____	$_____	$_____	_____
Child Life Insurance	$_____	$_____	$_____	_____

I have been given the opportunity to enroll in my employer's Optional Life Insurance plans. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to the Life Insurance carrier and understand my request for coverage may be denied.

In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual.

I hereby apply for (or request change in) coverages as indicated above for which I am eligible under contracts of group insurance issued to my employer. I understand that some coverages require approval of my insurability before they become effective, I authorize payroll deductions for my share of the premiums.

DATE OF APPLICATION	SIGNATURE OF EMPLOYEE