Public Employees Benefits Board (PEBB) – Group #123731
Underwritten by ReliaStar Life Insurance Company

Life Insurance Change Form

Use this form if you enroll more than 60 days after initial eligibility, or if you want to change your current PEBB life insurance (including after job transfers between agencies).

Employees	Payroll or benefits office staff
• If you're enrolling within 60 days of eligibility, use the *Life Insurance Enrollment Form*. • Type or print clearly in ink. • Complete Sections 1 – 6 below. • Return this form to your payroll or benefits office. • Return a completed *Life Insurance Evidence of Insurability Form* to ReliaStar Life (address on back.)	• Review Sections 1 – 6 for completeness and accuracy, and complete Section 7. • Key Section 3 before sending the form to ReliaStar Life Insurance Company to obtain approval (address on back.)

SECTION 1: Personal Information Employee completes this section.

Social Security Number **(required)**	Last Name	First Name	Middle Initial	Employee I.D. Number
Street Address				Apartment Number
City	State	ZIP Code + 4	Phone Number–Daytime ( )	Phone Number–Evening ( )
Date of birth	❑ Male ❑ Female	Do you or any family member you are requesting coverage for smoke? ❑ Yes ❑ No *If no, complete and sign Section 4.*		

SECTION 2: Type of Change Employee completes this section.

❑ Marriage or establishment of a qualified domestic partnership
Date of marriage or date partnership established/registered ____________

❑ Adding a spouse or qualified domestic partner after 60 days of marriage or established/registered domestic partnership

❑ Divorce or termination of domestic partnership

❑ Adding child(ren)

❑ Removing child(ren)

❑ Returning from leave of absence

❑ Changing coverage amounts after 60 days of initial eligibility

❑ Transfer of PEBB coverage from spouse's/qualified domestic partner's account (must be completed within 31 days of spouse's/partner's loss of coverage)

SECTION 3: Life/Accidental Death & Dismemberment (AD&D) Coverage Employee completes this section.

Decreases in coverage do not require approval. All coverage that requires approval is noted below. If you want to estimate your costs for this coverage, complete the Estimated Monthly Costs column below. (See rates on page 32 of the life/AD&D booklet.)

Type of Coverage and Current Coverage Amounts	Employee	Family	Estimated Monthly Cost
Part A–Basic Life *Paid by your employer.* $25,000 life; $5,000 AD&D	$25,000 life insurance $5,000 Accidental Death & Dismemberment	Not applicable	$0.00
Part B–Basic Spouse & Child(ren) Life Spouse/qualified domestic partner covered? ❑ Yes ❑ No Child(ren) covered? ❑ Yes ❑ No	Not applicable	*Check all that apply:* ❑ Add spouse or qualified domestic partner ($2,500) ***(requires approval)*** ❑ Remove spouse or partner ❑ Add child(ren) ($2,500 per child) ❑ Remove all child(ren)	$____________ ($0.52 per family per month)
Part B—Supplemental Spouse Life *If enrolling, must complete* Life Insurance Evidence of Insurability Form. Current amount $____________	Not applicable	*Fill in desired amount to replace current amount in increments of $1,000.* ***(Increase requires approval.)*** $____________ Up to ½ of employee's total Part C and Part D coverage. Spouse/qualified domestic partner must enroll in Part B Basic and employee must enroll in Part C, Part D, or both.	$____________
Part C–Optional Life *If enrolling, must complete* Life Insurance Evidence of Insurability Form. Current amount $____________ Does your current coverage automatically increase with pay increases? ❑ Yes ❑ No	*Fill in desired amount to replace current amount in increments of $1,000.* ***(Increase requires approval.)*** $____________ Minimum of ½ of employee's gross annual pay, up to employee's gross annual pay (based on full-time, 12-month pay rounded up to nearest $1,000). **If you request maximum gross annual pay only:** Do you want coverage to automatically increase as the pay increases? ❑ Yes ❑ No	Not applicable	$____________

continued on back

SECTION 3: Life/Accidental Death & Dismemberment (AD&D) Coverage Employee completes this section.

Type of Coverage and Current Coverage Amounts	Employee	Family	Estimated Monthly Cost
Part D–Supplemental Life *If enrolling, must complete* Life Insurance Evidence of Insurability Form. Current amount $______	*Fill in desired amount to replace current amount in increments of $1,000.* ***(Increase requires approval.)*** $______ Minimum of $1,000, up to a total of $350,000.	Not applicable	$______
Part E–Optional Accidental Death & Dismemberment Current amount $______ Coverage for dependents? ❑ Yes ❑ No	*Fill in desired amount to replace current amount in increments of $25,000.* $______ Minimum of $25,000, up to $250,000	❑ Do or ❑ Do not include this coverage for my dependents. *(See page 32 in life/AD&D booklet for coverage amounts.)*	$______
		ESTIMATED TOTAL	**$**

SECTION 4: Nonsmoker Certification Employee completes this section.

To qualify for the nonsmoker's discount, the applicant(s) must not have used any tobacco products in the past 12 months.

I certify that I have not smoked cigarettes, cigars, or pipes, or used chewing tobacco or nicotine gum within the past 12 months.

I understand that ReliaStar Life Insurance Company has the right to reduce my claims payment if I provide false information or if I don't notify my payroll or benefits office that I no longer qualify for the nonsmoker's discount.

Employee's signature ______________________ Date ______________

Spouse or qualified domestic partner's signature (if applying) ______________________ Date ______________

SECTION 5: Beneficiary Designation Employee completes this section.

See "Suggested Beneficiary Designations" on pages 35-36 of the life/AD&D booklet. Include full name of beneficiary, his or her relationship to you, social security number, date of birth, and whether the beneficiary is primary or secondary. You are the beneficiary for your enrolled family members.

Name	Relationship	Social Security Number	Date of birth	❑ Primary ❑ Secondary
Name	Relationship	Social Security Number	Date of birth	❑ Primary ❑ Secondary
Name	Relationship	Social Security Number	Date of birth	❑ Primary ❑ Secondary
Name	Relationship	Social Security Number	Date of birth	❑ Primary ❑ Secondary

SECTION 6: Authorization Employee completes this section.

By signing this form, I declare that the information I have provided is true, complete, and correct. I understand that knowingly providing false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company is a crime, and can result in imprisonment, fines, and denial of PEBB benefits.

The PEBB Benefits Services Program will verify eligibility for me and my family members.

I allow my employer to deduct money from my earnings to pay for any optional insurance I requested and approved by ReliaStar Life Insurance Company. This form replaces all previous forms and submissions I have made for PEBB life insurance.

The information collected about you is confidential. We will not release any information about you without your authorization, except to conduct our business or as required or permitted by law.

Employee's signature ______________________ Date ______________

SECTION 7: Agency/Carrier Information Payroll or benefits office completes this section.

Agency code	**Subagency code**	**Employee's gross annual salary**	
Employee hire date	**Original insurance eligibility date**	**Date coverage amounts keyed by payroll/benefits office**	**Date sent to carrier**
Change effective dates for	**Part B Basic Spouse**	**Part B Basic Children**	
Part B Supplemental Spouse	**Part C**	**Part D**	**Part E**