

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 <ul style="list-style-type: none"> If you're enrolling within 60 days of eligibility, use the <i>Life Insurance Enrollment Form</i>. Type or print clearly in ink. Complete Sections 1 – 6 below. Return this form to your payroll or benefits office. Return a completed <i>Life Insurance Evidence of Insurability Form</i> to ReliaStar Life (address on back.) 	Payroll or benefits office staff <ul style="list-style-type: none"> 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.)
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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	<input type="checkbox"/> Male <input type="checkbox"/> Female	Do you or any family member you are requesting coverage for smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If no, complete and sign Section 4.</i>		

SECTION 2: Type of Change Employee completes this section.	
<input type="checkbox"/> Marriage or establishment of a qualified domestic partnership Date of marriage or date partnership established/registered _____	<input type="checkbox"/> Removing child(ren)
<input type="checkbox"/> Adding a spouse or qualified domestic partner after 60 days of marriage or established/registered domestic partnership	<input type="checkbox"/> Returning from leave of absence
<input type="checkbox"/> Divorce or termination of domestic partnership	<input type="checkbox"/> Changing coverage amounts after 60 days of initial eligibility
<input type="checkbox"/> Adding child(ren)	<input type="checkbox"/> 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 "Premium Rates" in the life/AD&D booklet.)	

Type of Coverage and Current Coverage Amounts	Employee	Family	Estimated Monthly Cost
Part A–Basic Life <i>Paid by your employer.</i> \$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? <input type="checkbox"/> Yes <input type="checkbox"/> No Child(ren) covered? <input type="checkbox"/> Yes <input type="checkbox"/> No	Not applicable	<i>Check all that apply:</i> <input type="checkbox"/> Add spouse or qualified domestic partner (\$2,500) (requires approval) <input type="checkbox"/> Remove spouse or partner <input type="checkbox"/> Add child(ren) (\$2,500 per child) <input type="checkbox"/> Remove all child(ren)	\$ _____ (\$0.50 per family per month)
Part B—Supplemental Spouse Life <i>If enrolling, must complete Life Insurance Evidence of Insurability Form.</i> Current amount \$ _____	Not applicable	<i>Fill in desired amount to replace current amount in increments of \$1,000. (Increase requires approval.)</i> \$ _____ 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 <i>If enrolling, must complete Life Insurance Evidence of Insurability Form.</i> Current amount \$ _____ Does your current coverage automatically increase with pay increases? <input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Fill in desired amount to replace current amount in increments of \$1,000. (Increase requires approval.)</i> \$ _____ 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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Not applicable	\$ _____

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	Fill in desired amount to replace current amount in increments of \$25,000. \$ _____ Minimum of \$25,000, up to \$250,000	<input type="checkbox"/> Do or <input type="checkbox"/> Do not include this coverage for my dependents. (See "Premium Rates" 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" section. 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. Indicate any other beneficiaries such as an estate, trustee, or business partner under "Other Designation(s)" below. Use another sheet of paper if you have additional beneficiaries or need more space. You are the beneficiary for your enrolled family members.

Name	Relationship	Social security number	Date of birth	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary
Name	Relationship	Social security number	Date of birth	<input type="checkbox"/> Primary <input type="checkbox"/> Secondary

Other Designation(s)

<input type="checkbox"/> Primary <input type="checkbox"/> Secondary	Type of beneficiary
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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 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	