GROUP INSURANCE ENROLLMENT / CHANGE FORM

PLEASE PRINT OR TYPE LEGIBLY

Policy Number	**Suffix**	**Employer Name (Policyowner)**	**Social Security No.**
695718		**City of Grand Junction**	

Member Name (Last, First, M.I): _____

Complete Address: _____

Phone Number : _____

Male ☐ **Female** ☐	**Birthdate** ____ /_____/_____ Mo Day Year	**Date Employed** ___/___/___ Mo Day Year	**Eff. Date of Insurance** _____/_____/_____ Mo Day Year

Workplace Location (State) **COLORADO**	**Employer's Plan Includes:** ☐ Smoker ☐ Non-Smoker ☑ LIFE / AD&D ☑ LTD ☐ DEP LIFE (Waived) _____ (initial) ☐ DEP LIFE (if selected ONLY)
Occupation	**Hours Worked each week For This Employer** *(not Incl. Overtime):* _____ **Base Earnings From This Employer** Hr. ☐ Wk ☐ Mo. ☐ Yr. ☐ $_____

BENEFICIARY INFORMATION – Complete for Group Life and AD&D Insurance

Primary Full Name	Address & Phone No.	SSN	DOB	Relationship	%
Contingent Full Name	**Address & Phone No.**	**SSN**	**DOB**	**Relationship**	**%**

Percentage must = 100% for Primary or Contingent category.

CHANGE OF DEPENDENTS INSURANCE ONLY:

I wish to: ☐ **ADD** ☐ **Terminate Insurance on the following dependent(s)**

Full Name	Male / Female	SSN	DOB	Relationship

I apply for Insurance under the Group Insurance Plan. I authorize deductions from my wages to cover my contribution, if required, toward the cost of my insurance.

_____ _____

Employee Signature **Date**

BENEFICIARY CHANGE INFORMATION – continued

Print all information legibly.

Enter information below. If additional space is needed use the back of this form or attach a sheet to this form. Percentage must = 100% for Primary or Contingent category.

Primary Full Name	Address & Phone No.	SSN	DOB	Relationship	%
Contingent Full Name	**Address & Phone No.**	**SSN**	**DOB**	**Relationship**	**%**

Percentage must = 100% for Primary or Contingent category.

I apply for Insurance under the Additional Life Insurance Plan. I authorize changes to deductions from my wages to cover my contribution, <u>if required,</u> toward the cost of my insurance.

_____

Employee Signature **Date**