Ensure the most current form is submitted. Refer to EMACS Forms/Procedures website.

MINNESOTA LIFE

Life Insurance and AD&D Enrollment Form
County of San Bernardino Policy Number 33772 & 33773

Must print in Black or Blue ink ONLY

Employee ID	Last Name, First Name	Department
Date of Hire	**Date of Birth**	**Age**

Voluntary Life Insurance - Employee ☐ Before-Tax ☐ After-Tax

You have the opportunity to re-enroll or enroll for the first time in the County of San Bernardino's Voluntary Life Insurance plan. You may elect coverage in increments of $10,000, subject to a maximum of $700,000. If you elect an amount that exceeds $250,000, you will need to provide evidence of good health that is satisfactory to Minnesota Life before the excess can become effective. Refer to the current Employee Benefits Guide to determine your bi-weekly cost for this coverage. If no election is made, after-tax deduction will be applied. ***You must complete the Beneficiary Designation section below.***

☐ I elect to **enroll** or **re-enroll** in the Voluntary Life Plan. *Total amount of voluntary term life insurance requested $ _____

☐ I elect to **decline** the Voluntary Life Plan.

*Note: Benefit reductions begin at age 70. If you are over the age of 70, the bi-weekly costs shown are calculated based on your reduced benefit amount, not the employee life amount shown. Please see your benefits administrator for further information.

Voluntary Life Insurance - Spouse/Domestic Partner (offered on after-tax basis only)

You can enroll your spouse or registered domestic partner in the Voluntary Life Insurance plan. You may elect coverage in increment of $10,000, subject to a maximum of $250,000. Your dependent's coverage cannot exceed your total combined basic and supplemental life coverage, up to $250,000. If you elect a coverage amount that exceeds $50,000, or enrolling under one of the EOI-required enrollment opportunities, you will need to provide evidence of good health that is satisfactory to Minnesota Life before the excess can become effective. All dependent supplemental life premium are paid on after-tax basis. ***Beneficiary Info: You are the beneficiary of your spouse/domestic partner supplemental life benefits if living, otherwise benefit will be paid to your estate.***

☐ I elect to **enroll** or **re-enroll** in the Voluntary Spouse/Domestic Partner Life Plan. **Total amount of voluntary term life insurance requested $ _____

☐ I elect to **decline** the Voluntary Spouse/Domestic Partner Life Plan.

Spouse/Domestic Partner Last Name, First Name	SSN	Relationship	Date of Birth

**Note: Benefit reductions also applies on Spouse/Domestic Partner coverage.

Voluntary Life Insurance - Child(ren) (offered on after-tax basis only)

You can enroll your eligible child(ren) under the age of 26 in the Voluntary Life Insurance plan. You may elect coverage in increment of $5,000, subject to a maximum of $20,000. Your dependent's coverage cannot exceed your total combined basic and supplemental life coverage, up to $20,000. All amounts for child(ren) coverage are guaranteed and one election will cover all eligible child(ren). Refer to the current Employee Benefits Guide to determine your bi-weekly cost for this coverage. All dependent supplemental life premium are paid on after-tax basis. ***Beneficiary Info: You are the beneficiary of your children supplemental life benefits if living, otherwise benefit will be paid to your estate.***

☐ I elect to **enroll** or **re-enroll** in the Voluntary Child(ren) Life Plan. ***Total amount of voluntary term life insurance requested $ _____

☐ I elect to **decline** the Voluntary Child(ren) Life Plan.

Child(ren) Last Name, First Name	SSN	Relationship	Date of Birth

***Note: One election will cover all eligible child(ren).

DISTRIBUTION:
New Hire- EMACS-HR (0030)
Mid-Year- HR-EBSD (0440)

Voluntary Accidental Death & Dismemberment (AD&D) ☐ Before-Tax ☐ After-Tax

Plan Option	Employee	Spouse or Domestic Partner	Each Child
1	$10,000	$5,000	$3,125
2	$25,000	$12,500	$6,250
3	$50,000	$25,000	$12,500
4	$100,000	$50,000	$25,000
5	$150,000	$75,000	$25,000
6	$200,000	$100,000	$25,000
7	$250,000	$125,000	$25,000

AD&D is offered to all units except Fire Fighters, Per Diem Nurses, Safety and Safety Management and certain contract positions.

☐ I elect to **enroll** in the Voluntary AD&D plan. Refer to the current Employee Benefits Guide to determine your bi-weekly cost for this coverage.

Select a plan option: ☐ Option 1 ☐ Option 2 ☐ Option 3 ☐ Option 4 ☐ Option 5 ☐ Option 6 ☐ Option 7

Select one of the following coverages: ☐ EMPLOYEE ONLY ☐ FAMILY

☐ I elect to **decline** the Voluntary AD&D plan..

Beneficiary Designation

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship, date of birth and distribution percentage. Contingent beneficiaries collect only if all primary beneficiaries predecease the insured. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example, "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

	Full Name	Address	SSN	Relationship	Date of Birth	%
Primary						
Contingent						

A beneficiary for employee Life Insurance may be changed upon written request

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Employee Confirmation

I have been given the opportunity to enroll in the County of San Bernardino's Group Voluntary Life & AD&D Insurance plans with Minnesota Life. I understand that for any amount which exceeds the guarantee issue amount, I will be required to provide evidence of good health that is satisfactory to Minnesota Life and understand my request for coverage may be denied. I authorize my employer to make the appropriate payroll deductions from my wages. I am not now disabled and I am performing all the duties of my occupation on a full-time basis.

Employee Signature	Date

FOR OFFICE USE ONLY		
EOI Required	☐ Employee	☐ Spouse/Domestic Partner

FOR HR USE ONLY	
Processed By (Employee ID)	**Date**

DISTRIBUTION:
New Hire- EMACS-HR (0030)
Mid-Year- HR-EBSD (0440)