CITY OF MINNEAPOLIS – OPTIONAL LIFE ENROLLMENT/CHANGE FORM

Employee Name ______________________________ Employee ID # ________________ Effective Date ______________

Home Phone ______________________________ Work Phone ________________

Life Insurance

- If you do not have optional life insurance, you may apply for coverage at any time by completing an evidence of insurability packet. To obtain a evidence of insurability packet, contact the Benefits Office at 612-673-3333.
- If you are enrolled in optional life insurance and pay for coverage with after-tax contributions, you can cancel or decrease your coverage at any time. You may also cancel dependent life insurance at any time. These changes can be made by completing this form.
- If you are enrolled for optional life insurance and experience a qualified life event, you can increase your optional life insurance by one level to a maximum of $500,000. Depending on the event, you may also be able to enroll for dependent life insurance.

OPTIONAL EMPLOYEE LIFE INSURANCE

_______ As a result of a life status change, I elect to increase my optional life insurance benefit amount by one times annual pay, not to exceed the lessor of five times pay or $500,000. To elect, employee must be currently enrolled in optional life insurance.

_______ I pay for optional employee life insurance with after-tax contributions and elect to waive coverage as of the effective date shown above.

OPTIONAL DEPENDENT LIFE INSURANCE

______ As a result of a life status change, I elect to enroll in my eligible dependents in dependent life insurance.

______ I elect to waive coverage as of the effective date shown above.

Please fill in percent of benefit for primary and contingent beneficiaries. Beneficiaries are considered to be primary unless specified as contingent (CON). The contingent is entitled to the life insurance benefit only in the event the primary beneficiary(s) is deceased at the time of payment. The total of all primary percentages must equal 100% and the total of all contingent percentages must equal 100%.

Dependent/Beneficiary Info DEPENDENT/BENEFICIARY NAME	% BEN	CON	RELATIONSHIP	DOB	M/F

Some of the requested information on this form is private data under the Minnesota Government Data Practices Act, Minn. Stat. Chapter 13. The data requested allows Benefit staff to verify eligibility and enroll you and your dependents in health plan(s) and allows the plan provider(s) the ability to establish an enrollment record for you and your dependents. You are not required to provide this information, however, failure to do so may result in ineligibility and non-enrollment. This form may be available to City and plan provider employees or agents, labor union representatives, arbitrators and administrative hearing examiners, State and Federal courts, and attorneys representing any of the mentioned individuals or entities, or to others through subpoena or pursuant to Federal and State law

By my signature below, I authorize the deductions necessary (pre-tax or after-tax as applicable) to ensure coverage under my plan choices as indicated above.

SIGNATURE: ____DATE: ______________________

Minneapolis
City of Lakes

Revised 7/2015