Seattle
Department of Human Resources

Accidental Death and Dismemberment Insurance Enrollment & Change Form

Employee Information: (Please print)

Last Name	First Name	Employee ID# or Last 4-digits of SSN	Birth Date (mm/dd/yyyy)

Enrollment Status: (Please select one)

○ New hire ○ Change coverage (within 30-day enrollment period) ○ Reduce coverage (mid-year change) ○ Canceling coverage (mid-year change) ○ Decline participation	Qualifying Events (Apply for or Changing Coverage): ○ New Marriage / Domestic Partnership ○ Add Newborn/Adoption or otherwise acquiring a newly eligible child

Select one option (A, B, C or D):

Reset this section

For applicable rates and principal sum amounts refer to your Employee Benefits Guide at https://bit.ly/benadd1.

○ **Option A – Apply for New Coverage**

○ **Yes**, I am applying for Accidental Death and Dismemberment insurance according to the terms of the group policy issued to the City of Seattle. I authorize deductions from my salary for the below coverage amount I am required to make toward the cost of this insurance.

○ **Individual** **OR** ○ **Family** **Coverage Amount** (Principal Sum) **$**

○ **Option B – Reduce Coverage (mid-year change)**

○ **Yes,** I would like to make a mid-year change to reduce my current coverage**.** I authorize reduced deductions from my salary for the below coverage amount I am required to make toward the cost of this insurance.

○ **Individual** **OR** ○ **Family** **Reduced Coverage Amount** (Reduced Principal Sum) **$**

○ **Option C – Change Plans (qualifying event)**

○ **Yes,** I would like to make a mid-year change to change my current plan from Individual to Family or vice versa due to a qualified status change**.** I authorize deductions from my salary for the below coverage amount I am required to make toward the cost of this insurance.

○ **Individual to Family** **New Coverage Amount** (Principal Sum) **$**
○ **Family to Individual** **New Coverage Amount** (Principal Sum) **$**

○ **Option D – Cancel Coverage or Decline Participation**

○ **No**, I do not want to participate, **or** I would like to cancel my current insurance coverage.

Beneficiary Information

List the beneficiary(ies) and specify the percentage of benefit for each beneficiary and if any beneficiary is contingent. Primary beneficiary means the person listed will receive the benefit. Contingent beneficiary means the person listed only receives the benefit if your named primary beneficiary is deceased. Your primary and contingent beneficiary percentage amounts must total 100% for each designation. However, you are not required to list a contingent beneficiary. If more space is required, use a separate list, sign, date and attach to this form.

Last Name (Print)	First Name	Address	◯ Primary ◯ Contingent	% of Benefit % of Benefit
Last Name (Print)	First Name	Address	◯ Primary ◯ Contingent	% of Benefit % of Benefit
Last Name (Print)	First Name	Address	◯ Primary ◯ Contingent	% of Benefit % of Benefit
Last Name (Print)	First Name	Address	◯ Primary ◯ Contingent	% of Benefit % of Benefit

Acknowledgement Signature:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the insurance company. Penalties may include imprisonment, fines and denial of insurance benefits.

By signing below, I declare that the information on this form is true, correct and complete to the best of my knowledge; that I have read and understand the enrollment form and descriptive material covering the options provided under this plan. I authorize the insurance carrier to obtain, examine or release information needed to process claims for myself or my family.

Employee's Signature: Date (mm/dd/yyyy):

BENEFITS ADMINISTRATION USE ONLY:	
Coverage Effective Date:	HRIS Entry:
Payroll Adjustment PPE:	Benefits Rep. Signature & Date: