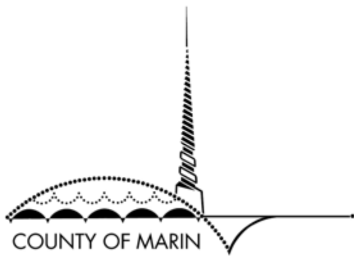

DEPARTMENT OF

HUMAN RESOURCES

Our Mission: To create a thriving organization, providing meaningful careers in public service.

LIFE/LONG TERM DISABILITY INSURANCE CHANGE FORM

Instructions: To drop optional Life and/or LTD insurance coverage during Open Enrollment, complete this form and return to Human Resources by the Open Enrollment deadline.

EMPLOYEE NAME________________________________ DOB_______________________

PERSONNEL NUMBER _____________________ TELEPHONE_______________________

DEPARTMENT____

I wish to drop the following optional insurance coverage with the understanding that I will have to apply for coverage, which is subject to the insurance carrier's refusal of coverage, should I wish to enroll at a later time.

Supplemental Life Insurance

Double Supplemental Life Insurance

Dependent Life Insurance

Long Term Disability Insurance

Change from Double Supplemental Life to Supplemental Life Insurance

______________________________ ______________________________

Signature of Employee *(required)* Date

______________________________ ______________________________

Signature of Spouse *(if change affecting spouse coverage)* Date

______________________________ ______________________________

Signature of Employer/Plan Administrator Date

FOR EMPLOYER/PLAN ADMINISTRATOR USE

Date received	Date processed	Processed by

Return to the Human Resources Department, Room 415