



City of Madison
GROUP TERM LIFE INSURANCE, DEPENDENT LIFE, and
ACCIDENTAL DEATH AND DISMEMBERMENT
ENROLLMENT/CHANGE FORM

Submit completed form to:
City of Madison Human Resources Department
215 Martin Luther King Jr Blvd Suite 261, Madison, WI 53703

Check all applicable boxes:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Initial Enrollment* | <input type="checkbox"/> Reinstate Coverage | <input type="checkbox"/> Reduce Coverage | <input type="checkbox"/> Remove Dependent Coverage |
| <input type="checkbox"/> Increase Coverage* | <input type="checkbox"/> Information Change | <input type="checkbox"/> Beneficiary Change | <input type="checkbox"/> Waive/Cancel Coverage |

* An increase in coverage or enrollment beyond 30 calendar days from date first eligible requires either an eligible qualifying event (deadlines and restrictions apply) or an approved Evidence of Insurability (EOI) Application

SECTION 1: <i>Employee Information and Coverage Elections</i> (COMPLETION OF THIS SECTION IS REQUIRED)		
PRINT NAME (<i>Last, First, Middle Initial</i>)		DATE OF BIRTH (<i>mm/dd/yyyy</i>)
List any Former Name(s) (<i>Last, First, Middle Initial</i>) (Separate multiple former names with a semicolon (;))		
DEPARTMENT NAME	DATE OF PERMANENT HIRE	MUNIS ID # (EMPLOYEE ID #)
SELECT EMPLOYEE COVERAGE: <input type="checkbox"/> BASIC COVERAGE only <input type="checkbox"/> BASIC plus SUPPLEMENTAL COVERAGE: <input type="checkbox"/> PLUS 50% <input type="checkbox"/> PLUS 100% <input type="checkbox"/> PLUS 200%		SELECT DEPENDENT COVERAGE: (<i>units of coverage for employee's spouse and/or child(ren)</i>) <input type="checkbox"/> 1 UNIT or <input type="checkbox"/> 2 UNITS or <input type="checkbox"/> NONE <i>Beneficiary for Dependent Coverage is the Employee</i>
SECTION 2: <i>Beneficiary Designation</i>		
BENEFICIARY DESIGNATION: PRINT (<i>See reverse side for suggested wording</i>)		
Primary: _____		
Secondary: _____		
SECTION 3: <i>Acceptance of Coverage and/or Acknowledgment of Beneficiary Designation</i>		
<input type="checkbox"/> I hereby request the amount of life insurance for which I am eligible and authorize the deduction from my earnings of the amount required to cover my share of the premiums. I reserve the right to revoke this deduction authorization and thereby understand that coverage ceases at any time on written notice.		
<input type="checkbox"/> Under and subject to the terms of the Group Policy, I hereby revoke any former Designation of Beneficiary by me made, and I now designate my Beneficiary or Beneficiaries as indicated above.		
Signature _____		
Date Signed _____		
SECTION 4: <i>Waive or Cancel Coverage</i> (COMPLETE THIS SECTION ONLY IF WAIVING/CANCELING COVERAGE)		
<input type="checkbox"/> I do <u>not</u> wish to participate in the City of Madison's Group Life Insurance, Dependent Life, and AD&D Plan.		
Signature _____		
Date Signed _____		

INSTRUCTIONS

1. Complete all sections of the form that are relevant to the enrollment/change that you are making.
2. The Signature of the Insured must be in non-erasable ink. Typed signatures, including DocuSign, are not accepted.
3. If the proposed beneficiary is a married woman, fill in her own given first and middle names, not those of her husband.
4. If you have named more than one beneficiary and have not designated the share for each, the benefits will be paid equally or to the survivor.
5. If your beneficiary is a minor (under age 18 in the State of Wisconsin), benefits will not be released directly to the minor, but instead to the court-appointed guardian of the estate (or property) of the minor. Guardianship of a minor's "person" is not the same as guardianship of a minor's property.

EXAMPLE WORDING OF TYPICAL BENEFICIARY DESIGNATIONS

1. **One beneficiary only:** Mary E. Doe, Wife. (A married woman should not be designated as Mrs. John Doe)
2. **Two beneficiaries (equal amounts):** John H. Doe, Father, and Mary E. Doe, Mother, equally or the survivor
3. **Three or more beneficiaries (equal amounts):** John H. Doe, Father, Mary E. Doe, Mother, and Stella Doe, Sister, equally or the survivor(s).
4. **Unequal amounts:** 75% to John H. Doe, Husband, 25% to Elizabeth M. Jones, Mother.
5. **Primary and Contingent beneficiaries:** John H. Doe, Husband, if living; otherwise to Jeff W. Doe, Son, and Jane M. Smith, Daughter, equally or the survivor.
6. **Partnership beneficiary:** Smith, Jones, and Brown, a partnership consisting of John A. Smith, Elizabeth M. Jones, and Henry D. Brown.
7. **Common Disaster Clause:** John H. Doe, Husband, if living on the 15th day after the death of the insured; otherwise to Jeff W. Doe, Son, and Jane M. Smith, Daughter, equally or the survivor.
8. **Estate of the Insured** (certified estate papers issued by the Court are required)
9. **Trust** (a Charitable, Living, or Testamentary trust may be named. Employees are strongly encouraged to seek professional advice to correctly provide this option.)

For additional information on this plan, visit <https://www.cityofmadison.com/human-resources/benefits/life-insurance>