INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Offered by Life Insurance Company of North America

Employer: City of San Rafael

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ **Social Security #** _____ **Birthdate** _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Gender: ____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE

☐ I am currently married and my date of marriage is: _____

My Spouse's Information

Name _____ **Social Security #** _____

Birthdate _____ Gender _____

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employer-Paid (Basic) Term Life Insurance Policy # FLX 0960830		
Applicant	**The coverage below is provided by your employer at no cost to you.**	
Employee	$5,000	Guaranteed Coverage*: $5,000
Spouse	50% of employee's coverage amount	
Children	$2,000	

Employee-Paid (Voluntary) Term Life Insurance Policy # FLX 096083		
Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Units of $10,000 up to $500,000. Guaranteed Coverage: $200,000	☐ $10,000 ☐ $200,000* ☐ $500,000** ☐ Other _____ *Amount must be a multiple of $10,000.* ☐ Decline Coverage
Spouse	Units of $5,000 up to $250,000. Guaranteed Coverage: $25,000	☐ $5,000 ☐ $25,000* ☐ $250,000** ☐ Other _____ *Amount must be a multiple of $5,000.* ☐ Decline Coverage
Child	Units of $2,000 up to $10,000.	☐ $2,000 ☐ $10,000** ☐ Other _____ *Amount must be a multiple of $2,000.* ☐ Decline Coverage

Employer-Paid (Basic) Long-term Disability Insurance Policy # LK 0960715		
Applicant	**The coverage below is provided by your employer at no cost to you.**	
Employee	66.7% of your monthly covered earnings, to a maximum of $1,000 per month.	
Employee-Paid (Voluntary) Long-term Disability Insurance Policy # LK 0960715		
Applicant	Review your available plan below before accepting or declining coverage.	
Employee	Benefit Percentage: 66.67% Maximum Monthly Benefit Amount: $1,000	☐ Accept Coverage ☐ Decline Coverage

Please turn to other side to complete enrollment process.
Be sure to make a copy for your records.

***This is the maximum amount that you can choose under this plan.*
All coverage elected during this enrollment period will take effect on the latest of 05/01/2005, the date your election form is received by your employer, or if applicable the day your Evidence of Insurability Form is approved by the Insurance Company.

SIGN HERE TO ACCEPT YOUR DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to New York Life Group Benefit Solutions' approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by CA: Life Insurance Company of North America.

Please Sign Here Signature _____ Date _____

Created on 11/2021.