Group Life Insurance Enrollment Worksheet

POLICYHOLDER NAME: Intergovernmental Personnel Benefit Cooperative

EMPLOYER NAME: _____

Return completed and signed form to your Benefits Office.

A. EMPLOYEE INFORMATION

First Name | Middle Initial | Last Name

Street Address		City	State	Zip Code
Date of Birth (Month, Day, Year)	Social Security Number	Date of Employment	Salary	Gender ☐ Male ☐ Female

B. BASIC LIFE

Amount $ _____ Insurance Class: _____ Effective Date: _____

C. SUPPLEMENTAL LIFE

Employee ☐ Increase
Current Amount $_____ ☐ Decrease Amount $_____ Grand Total $_____ Effective Date _____
Do you want to apply for employee supplemental accidental death & dismemberment insurance (matches life amount)? ☐ Yes ☐ No

Spouse ☐ Increase
Current Amount $_____ ☐ Decrease Amount $_____ Grand Total $_____ Effective Date _____
Do you want to apply for spouse supplemental accidental death & dismemberment insurance (matches life amount)? ☐ Yes ☐ No

Child ☐ Increase
Current Amount $_____ ☐ Decrease Amount $_____ Grand Total $_____ Effective Date _____
Do you want to apply for child supplemental accidental death & dismemberment insurance (matches life amount)? ☐ Yes ☐ No

Dependent Life Package
☐ Elect ☐ Waive/Cancel Effective Date _____

D. SPOUSE INFORMATION

First Name	Middle Initial	Last Name	Marriage Date
Date of Birth (Month, Day, Year)	Is your spouse also an employee covered under this plan? ☐ Yes ☐ No		Gender ☐ Male ☐ Female

E. CHILDREN INFORMATION – (List names and date of birth for your eligible children)

F. AUTHORIZATION

I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for supplemental insurance coverage.

Employee Signature	Daytime Telephone Number	Evening Telephone Number	Date Signed