Lee County Board of County Commissioners Enrollment Form

Group Life Insurance

Please return completed form to your Human Resources department.

Employer Name	Group Policy Number
Lee County Board of County Commissioners	05-291182
Employer Address (City, State, Zip Code)	Coverage Effective Date
2115 Second Street, Fort Myers, FL 33901	

Employee Name (Last, First, Middle)	Department/Entity
Address (City, State, Zip Code)	

Social Security Number	Date of Birth (MM/DD/YY)	Gender	Marital Status
		☐ Male ☐ Female	☐ Single ☐ Divorced ☐ Married ☐ Widowed
Hire Date (MM/DD/YY)	**Annual Salary**	**Type of Enrollment**	
	$	☐ New Employee ☐ Late Entrant - EOI ☐ Qualified Life Event	

Coverage Elections

Please indicate your coverage elections below.

The Employee must enroll in Optional life coverage to elect Optional Dependent life coverage. The total spouse coverage requested ($1,000 increments from $25,000 to $250,000) is not to exceed 50% of the employee's optional life coverage. The total dependent coverage requested ($5,000 increments to $25,000) is not to exceed 50% of the employee's optional life coverage. Completion of this enrollment form does not guarantee coverage. Evidence of Insurability may be required. Please see your plan booklet for additional information.

Type of Coverage	Selection	Coverage Elected
Employee Optional Life	☐Yes ☐No	$_____
Spouse Optional Life	☐Yes ☐No	$_____
Child(ren) Optional Life	☐Yes ☐No	$_____

If electing for Dependent Coverage (Spouse and Child), please complete the following:		
Spouse Name:	Date of Birth:	☐ Female ☐ Male
Child Name:	Date of Birth:	☐ Female ☐ Male
Child Name:	Date of Birth:	☐ Female ☐ Male
Child Name:	Date of Birth:	☐ Female ☐ Male
Child Name:	Date of Birth:	☐ Female ☐ Male
Dependent Child(ren) coverage is available to eligible dependent child(ren) under 26 years of age.		

Employee Signature and Authorization

☐ ACCEPT: I declare that all information given in this enrollment form is true and complete to the best of my knowledge and belief. I request coverage under my employer's plan of benefits as indicated above. I authorize my employer to deduct from my earnings my contributions for the coverage(s) selected. I understand that with respect to coverages I have declined, Liberty Mutual Insurance has the right to require Evidence of Insurability in order to consider any later request to change this decision and that my request may be denied. I am an employee in active employment working at the employer's regular place of business.

☐ DECLINE: I hereby decline all optional coverage as offered by my Employer. I certify that I have been given the opportunity by my Employer to enroll for coverage. I understand that Liberty has the right to require Evidence of Insurability in order to consider any later request to change this decision and that my request may be denied. I am an employee in active employment working at the Employer's regular place of business.

Employee Signature: Date: