LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE ENROLLMENT

ReliaStar Life Insurance Company, Minneapolis, MN
Telephone: 800-955-7736
A member of the Voya® family of companies

PLAN INFORMATION section to be completed by the Employer/Plan Sponsor. Remainder to be completed by the Employee. **All** new Life coverage or **any** increases in Life coverage will require evidence of insurability if plan participation requirements are not met. Any references to coverage being obtained without evidence of insurability in the sections below are only applicable if the plan participation requirements are met.

PLAN INFORMATION

Employer/Plan Sponsor Name Public Risk Innovation, Solutions and Management (PRISM) Effective Date of Coverage or Change _____
Group/Plan Number 316407 Account Number/Location Acct 184: County of Imperial
Class/Occupation _____
Date of Hire _____ Annual Salary $_____ Employment Status: ☐ Active Full-Time ☐ Active Part-Time ☐ Retired

This change is due to *(Check all that apply.)*:

☐ Initial Eligibility Following Hire ☐ Change in Coverage Amount ☐ Late Entrant [1] ☐ Other _____

[1] *A late entrant is an individual who is first enrolling after the initial available opportunity.*

EMPLOYEE INFORMATION

Employee Name *(First, Middle Initial, Last)* _____
Birth Date _____ SSN _____ Gender: ☐ Male ☐ Female
Employee ID Number _____ Work Phone (_____)_____ Home Phone (_____)_____
Address _____ City _____ State _____ ZIP _____

EMPLOYEE LIFE INSURANCE

Basic Life / AD&D Insurance Election

☑ Employee Only—Elect Coverage *(Note: Basic Life insurance is employer provided.)*

Supplemental Life Insurance

When you are initially eligible for Spouse coverage, you can elect up to $300,000 in coverage without evidence of insurability.

Supplemental Life Insurance Election

☐ I currently have supplemental life coverage of: $_____.
☐ I am applying for additional supplemental life coverage of: $_____. ($10,000 increments)
☐ Total supplemental life coverage (current plus additional): $_____.
☐ Waive coverage.

BENEFICIARY INFORMATION

(Designate your beneficiary(ies) below. Percentages must total 100%, using whole percentages only. If additional space is required please attach a separate signed and dated document with the same information for each beneficiary.)

	Name *(First, MI, Last)*	DOB	Gender	SSN / TIN	Relationship	%	Beneficiary Type
1			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			
2			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			
3			☐M ☐F				☐ Primary ☐ Contingent
	Address			**Phone ( )**			

SPOUSE LIFE INSURANCE *(The use of "spouse" in this form means a person insured as a spouse as described in the certificate of insurance or rider. This may include domestic partners or civil union partners as defined by the plan. Please contact the Employer for more information.)*

When you are initially eligible for Spouse coverage, you can elect up to $10,000 in coverage without evidence of insurability. Total Spouse coverage up to $250,000 is available if Spouse completes an Evidence of Insurability form subject to approval by the insurance company. Spouse coverage is not to exceed the employee's coverage amount.

Spouse Name *(First, Middle Initial, Last)* _____ Birth Date _____

Spouse Supplemental Life Insurance Election

☐ I currently have spouse supplemental life coverage of: $_____.
☐ I am applying for additional spouse supplemental life coverage of: $_____. ($10,000 increments)
☐ Total spouse supplemental life coverage (current plus additional): $_____.
☐ Waive coverage.

Note: The employee is the beneficiary for any Spouse insurance coverage.

CHILDREN LIFE INSURANCE

Coverage is not to exceed the employee's coverage amount

Children Supplemental Life Insurance Election (for each eligible child)

☐ I currently have children supplemental life coverage of: $_____.
☐ I am applying for additional children supplemental life coverage of: $_____. ($2,000 increments to a max of $10,000)
☐ Total children supplemental life coverage (current plus additional): $_____.
☐ Waive coverage.

Note: The employee is the beneficiary for any Children insurance coverage.

SPOUSE AND CHILDREN INFORMATION

Enter information below. If additional space is required please attach a separate document.

	Spouse Name *(First, MI, Last)*	DOB	Gender	SSN
			☐M ☐F	
	Address			**Phone ( )**

	Child Name *(First, MI, Last)*	DOB	Gender	SSN
1			☐M ☐F	
	Address			**Phone ( )**
2			☐M ☐F	
	Address			**Phone ( )**
3			☐M ☐F	
	Address			**Phone ( )**

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- I understand my coverage begins on the effective date assigned by ReliaStar Life Insurance Company, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee Signature _____ Date _____

FRAUD WARNINGS

Arkansas, Maine, Ohio, Oklahoma, Rhode Island, Tennessee, Washington, West Virginia: Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.