

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
Date of Birth (Month, Day, Year)			Social Security Number	Date of Employment
			Salary	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female

B. BASIC LIFE

Basic Life Amount \$ _____ **Insurance Class:** _____ **Effective Date:** _____

Dependent Life Package (\$10,000 spouse / \$5,000 child(ren)) Add **Effective Date:** _____

C. SUPPLEMENTAL LIFE

Employee	<input type="checkbox"/> Increase	Amount \$ _____	Grand Total \$ _____	Effective Date _____
Current Amount \$ _____	<input type="checkbox"/> Decrease			
Spouse	<input type="checkbox"/> Increase	Amount \$ _____	Grand Total \$ _____	Effective Date _____
Current Amount \$ _____	<input type="checkbox"/> Decrease			
Child	<input type="checkbox"/> Increase	Amount \$ _____	Grand Total \$ _____	Effective Date _____
Current Amount \$ _____	<input type="checkbox"/> Decrease			

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? <input type="checkbox"/> Yes <input type="checkbox"/> No		Gender <input type="checkbox"/> Male <input type="checkbox"/> 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
--------------------	--------------------------	--------------------------	-------------