CITY OF HOUSTON
VOLUNTARY LIFE INSURANCE

■ **ENROLLMENT** (First Request)

■ **CHANGE** (An employee has coverage and is requesting to change beneficiary(ies), add/drop spouse/dependent(s), decrease/increase coverage or cancel coverage.)

Employment Date:_____ **Effective Date of Coverage**_____

Employee I. D. Number	Department	Social Security No.	Sex
			☐ Male ☐ Female

Last Name	First Name	M.I.	Work Phone: ( )
Address	Apt No. / City	State	Zip Code

☐ **I ELECT TO APPLY** ☐ **I ELECT TO INCREASE** ☐ **I ELECT TO DECREASE**

New employees may apply for up to 3 x salary without providing a Medical History Statement. All other requests must be accompanied by a Medical History Statement which is subject to underwriting approval.

◯ **1 x Salary** ◯ **2 x Salary** ◯ **3 x Salary** ◯ **4 x Salary**

☐ **I decline Voluntary Life Insurance coverage.** ☐ **I elect to cancel my Voluntary Life Insurance.**

BENEFICIARY – Designation(s) must be clear. Your intent must not be questionable in order for the insurance company to properly pay the proceeds according to your wishes. It is important to name both a primary and a contingent beneficiary. **Note: Proceeds cannot be paid to a minor beneficiary.** Such proceeds will be held until the beneficiary reaches the age of majority, or proceeds may be paid to a court appointed guardian of the estate of the minor, or proceeds may be paid to a minor's trust account established prior to the insured's death.

In accordance with the conditions of the City of Houston Group Policy, I hereby revoke any previous designations of primary beneficiary(ies) and contingent beneficiary(ies) (if any) and designate as primary beneficiary(ies) and contingent beneficiary(ies) (if any) in the event of my death, the following:

PRIMARY BENEFICIARY DESIGNATION (Complete all information)

Full Name (Last, First, MI)	Relationship	Date of Birth	Social Security Number	Share %

Payment will be made to the above named beneficiary(ies) in equal shares or all to the survivor(s) unless otherwise indicated. TOTAL: 100%

In the event said primary beneficiary(ies) predecease(s) the insured, I designate as contingent beneficiary(ies):

CONTINGENT BENEFICIARY DESIGNATION (Complete all information)

Full Name (Last, First, MI)	Relationship	Date of Birth	Social Security Number	Share %

Payment will be made to the above named beneficiary(ies) in equal shares or all to the survivor(s) unless otherwise indicated. TOTAL: 100%

DEPENDENT COVERAGE (Complete all information)

Dependent means your spouse, biological child, stepchild, foster child, legally adopted child, dependent grandchild, and any child who lives with you and for whom you have legal guardianship. Children may be covered to age 21 or to age 25 if full-time students and dependent on you. Active and retired City of Houston employees are not eligible to be both a dependent and an insured under this policy. **Do not list currently enrolled dependent(s) on this form if you are requesting to increase their coverage.** However, you must list those dependent(s) on the Medical History Statement. ***Proof of dependency and full-time student status (dependents over age 21) are required. You are responsible to drop any ineligible dependent as of the date of ineligibility. You will default any premiums paid for an ineligible dependent.**

Add	Drop	Name	Date of Birth	Social Security Number	Relationship	Full Time Student Yes/No
					HUSBAND / WIFE	
					SON / DAUGHTER	
					SON / DAUGHTER	
					SON / DAUGHTER	

*Employee Signature:	Home Phone: ( )	Date:

***Your signature must be notarized if this form is not signed in the presence of a City of Houston Human Resources representative, payroll representative or pension representative.**

THE STATE OF TEXAS §
§
COUNTY OF _____ §

BEFORE ME, the undersigned authority, on this day personally appeared _____ known to me to be the person whose name is subscribed to the foregoing instrument, and acknowledge to me that he/she executed the same for the purposes and consideration therein expressed.

GIVEN UNDER MY HAND and seal of office this _____ day of _____20_____ A.D.

(SEAL) _____
Notary Public - Signature