Spouse/Domestic Partner Enrollment Form
Supplemental Life and AD&D Insurance

Instructions: Submit the completed form to City of Eugene Benefits Staff via fax to 541-650-3031, encrypted email to BenefitsStaff@eugene-or.gov, or mail to 940 Willamette Street Suite 200, Eugene OR 97401.

To be completed by Benefits Staff

Name of Employer: **City of Eugene**	Group/Plan Number: **GL-715287**	EE Date of Hire	Coverage/Change Effective Date
Enrollment is due to (check all that apply): ☐ Initial Eligibility ☐ Enrolling After Initial Eligibility Period ☐ Change in Coverage Amount ☐ Add Child Life Coverage ☐ Other (list): _____			

SPOUSE/DP INFORMATION: To be completed by Spouse/Domestic Partner

Employee Name (FIRST MI LAST)	Employee ID #	Employee Date of Birth
Spouse/DP Name (FIRST MI LAST)	☐ Female ☐ Male	Spouse/DP Date of Birth
Address (STREET, CITY, STATE, ZIP)		Date Married/Partnered

SPOUSE/DP COVERAGE: Review the insurance policy or benefit highlight summary prior to electing coverage.

Guaranteed Issue	When you are first eligible for Supplemental Life coverage, you can elect up to the Guaranteed Issue (GI) Limit without proof of good health. GI is available for Spouse/DP only within 31 days of employee's hire date or date of marriage/partnership, or if offered and elected during a Special Enrollment Period. • Guaranteed Issue (GI) Limit = $30,000
Supplemental Life Election	I am eligible and applying for Guaranteed Issue coverage of: $_____ **(A)** I currently have City of Eugene Supplemental Life coverage of: $_____ **(B)** I am applying for new or additional Supplemental Life coverage of: $_____ **(C)** Total Supplemental Life coverage (**(A)**+**(B)**+**(C)**): $_____ Total Supplemental Life coverage is available from $20,000 to $500,000, in $10,000 increments. Amounts not qualifying for Guaranteed Issue require an Evidence of Insurability form and are subject to approval by The Hartford. The benefit amount available is subject to a reduction schedule beginning at age 70.
Accidental Death & Dismemberment (AD&D) Election	☐ Waive ☐ Amount equal to Supplemental Life coverage.

CHILD LIFE COVERAGE

Child Life	Supplemental Life coverage is required to elect Child Life. Either the employee or the spouse/DP, but not both, may cover eligible dependent children from live birth up to age 26 years (or older if disabled prior to age 26).
Child Life Election	☐ Waive ☐ $5,000 ☐ $7,500 ☐ $10,000 The benefit elected above is payable for each eligible child. A single applicable premium amount covers all eligible children.

BENEFICIARY INFORMATION: Please ensure your beneficiary designation is clear so there are no questions of your intent. The percentages must total 100% for all Primary Beneficiaries and 100% for all Contingent Beneficiaries, if applicable. Please use and attach additional sheets if needed.

Beneficiary: Benefits are paid first to ALL primary beneficiaries, if living when benefits become payable.		
Name of Beneficiary (FIRST MI LAST)	Relationship to You	Benefit %
Address (STREET, CITY, STATE, ZIP)	Phone Number	☐ Primary ☐ Contingent
Name of Beneficiary (FIRST MI LAST)	Relationship to You	Benefit %
Address (STREET, CITY, STATE, ZIP)	Phone Number	☐ Primary ☐ Contingent
Name of Beneficiary (FIRST MI LAST)	Relationship to You	Benefit %
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Name of Beneficiary (FIRST MI LAST)	Relationship to You	Benefit %
Address (STREET, CITY, STATE, ZIP)	Phone Number	☐ Primary ☐ Contingent

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.
- I understand and agree that:
  - I may be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective; and
  - My insurance will go into effect and remain in effect only in accordance with the provisions, terms, conditions, and exclusions of the insurance policy issued to my employer; and
  - In the event of any difference between the enrollment form and the insurance policy, I will be bound by the insurance policy.
- Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

Employee Signature	Date Signed
Spouse/Domestic Partner Signature	Date Signed

Benefit Staff Use

Product(s)	Census	PS	PR	EE