

Mark all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

* APPLICANT	Your Name (Last, First, Middle)		Group Name City of Boulder		Group Number(s) 645601		
	Your Address		City		State	ZIP	
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation		
* LIFE	<i>Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.</i> Life Insurance <input type="checkbox"/> Life with AD&D Additional/Optional Life <input type="checkbox"/> Additional/Optional Life Your requested amount \$ _____ Dependents Life Insurance <input type="checkbox"/> Spouse requested amount \$ _____ Spouse Name _____ Date of Birth _____ <input type="checkbox"/> Children requested amount \$ _____						
	* DISABILITY	<i>Check with your Human Resources Department about coverage options available to you and Evidence Of Insurability requirements.</i> Long Term Disability <input type="checkbox"/> LTD					
		<i>This designation applies to Life/Life with AD&D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.</i>					
* BENEFICIARY	Primary - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit	
	Contingent - Full Name		Address		Soc. Sec. No.	Relationship % of Benefit	
* CHANGE	<i>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</i> <input type="checkbox"/> Add Dependent <input type="checkbox"/> Delete Dependent <input type="checkbox"/> Name Change <input type="checkbox"/> Beneficiary Change Date of add/delete _____ Former name _____ <input type="checkbox"/> Other _____						
	I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change.						
* SIGNATURE	Member/Employee Signature Required				Date (Mo/Day/Yr)		
Human Resources Department - Complete this section. Retain form for your records.							
Dvsn ID	Billing Cat.	Date of Hire/Rehire	Hrs. Worked Per Wk.	Earnings \$ _____	Per: <input type="checkbox"/> Hour <input type="checkbox"/> Wk <input type="checkbox"/> Mo <input type="checkbox"/> Yr		