

## Correction Officers Benevolent Association Supplemental Life Insurance- Employee Enrollment

<i>Name (Last, First, Middle)</i>	<i>Date of Birth</i>	<i>Social Security Number</i>	<i>Gender</i>
<i>Address</i>	<i>City</i>	<i>State</i>	<i>Zip</i>
<i>Date of Appointment</i>	<i>Date of Retirement (If Applicable)</i>		

### Dependent Information

#### Spouse

<i>Name (Last, First, Middle)</i>	<i>Gender</i>	<i>Date of Birth</i>
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#### Child

<i>Name (Last, First, Middle)</i>	<i>Gender</i>	<i>Date of Birth</i>

### Basic Life Amount (Mark Coverage Amount)

<i>Employee</i>	<i>Spouse</i>	<i>Child</i>
<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$5,000

### Employee Supplemental Life Amount (Mark Coverage Amount)

#### New Election\*

<input type="checkbox"/> \$50,000	<input type="checkbox"/> \$100,000	<input type="checkbox"/> \$200,000	<input type="checkbox"/>
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### Primary Beneficiary

<i>Full Name</i>	<i>Address</i>	<i>Relationship</i>	<i>% Benefit</i>

### Contingent Beneficiary

<i>Full Name</i>	<i>Address</i>	<i>Relationship</i>	<i>% Benefit</i>

If electing coverage, I authorize from my wages to cover contributions, if required, toward the cost of insurance. I understand that my deduction amount will change or costs change.

Signature \_\_\_\_\_ Date \_\_\_\_\_

\*Only \$50,000 will be effective immediately. Additional coverage will not be effective until you receive written approval. For a new election greater than \$50,000, please complete and submit a Medical History Statement.