San Diego & Imperial County Schools
Fringe Benefits Consortium

Enrollment Form for Basic Group Life Insurance

Policy Number: 875090		**District Name:** Del Mar Union School District		
Employee's Last Name	First Name	M.I.	Social Security Number	
Employment Date (M/D/Y)	Employee's Birth Date (M/D/Y)	Sex (M/F)	Occupation	Effective Date (M/D/Y)
Employee's Wages (Wk/Mo/Yr) $	Group Life Insurance Value: $ 50,000.00			

As a covered employee, you have the right to select a beneficiary in accordance with the provisions of your policy. You may also have the right to change the beneficiary designated. If more than one beneficiary is designated, payment of the death benefit will be made in equal share to each of the designated beneficiaries which survive the insured, unless some other allocation is specified by you in writing in accordance with the provisions of the policy. If no designated beneficiary survives the insured, settlement will be made in accordance with the terms of the policy.

Primary Beneficiary Name: Address:	Relationship	Social Security Number: % of benefit
Contingent Beneficiary Name: Address:	Relationship	Social Security Number: % of benefit
Additional Beneficiary: Address:	Relationship	Social Security Number: % of benefit
Additional Beneficiary: Address:	Relationship	Social Security Number: % of benefit
Additional Beneficiary: Address:	Relationship	Social Security Number: % of benefit

Common Beneficiary designations:

One Beneficiary Only:	Mary J. Smith, wife, friend, daughter, etc.
Two Or More Beneficiaries, Equal Amounts:	William S. Smith, father, Alice C. Smith, sister, and Richard B. Smith, brother, equally or to the survivors equally, or to the survivor.
Unequal Amounts:	50% to Mary J. Smith, wife, and 25% each to Alice C. Smith, sister, and Richard B. Smith, brother, the share of any deceased beneficiary to be paid in equal shares to the survivors, or to the survivor.
Primary And Contingent Beneficiary:	Mary J. Smith, wife, if living, otherwise the children born of the marriage of the insured to Mary J. Smith equally, or equally to the survivors, or to the survivor.
Trustee Beneficiary:	The Trust Company of Smith, Illinois as trustee under a Trust Instrument dated December 28, 1999.

I have read, understand, and agree to the provisions printed above and acknowledge that the information I have provided is accurate to the best of my knowledge. I further hereby authorize my employer to make necessary payroll deductions if required.

Insured's Signature: x_____ Date: _____.

Your spouse MUST sign this form if you are a resident of CA **and** you have designated someone other than your spouse as beneficiary.

Spouse's Signature: x_____ Date: _____.

BENEFICIARY DESIGNATION FORM INSTRUCTIONS

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group/employer.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your Company's benefits administrator or your own legal advisor.

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA).

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Does	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write, "See attached", on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Employee) and dated.**

BENEFICIARY DESIGNATION

THE HARTFORD

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designation(s) *(check only one box)*, I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group or employer and direct that the insurance proceeds payable under the policy be paid as indicated below.

Employee Name:	Employee ID Number:	Social Security Number: X X X X X ☐ ☐ ☐ ☐
Employee Address:		Telephone Number: ( )
Policyholder/Employer:		Policy Number:

NAMING YOUR GROUP LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact your Company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, We may, at Our option, pay the benefit to Your surviving spouse or to the executors or administrators of Your estate.

PRIMARY BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____%

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____%

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____%

CONTINGENT BENEFICIARY(IES)

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____%

Name: _____ Date of Birth: _____

Address: _____ Telephone Number: (___) _____

Social Security Number: _____ Relationship: _____ Benefit Percent: _____%

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state - Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, or Wisconsin - you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Employee: _____ **Date:** _____

Please note that in no event may a beneficiary be changed by a Power of Attorney (POA)