Group Life Insurance Enrollment Worksheet

EMPLOYER NAME: Okaloosa County BOCC **LIFE POLICY NUMBER: 34674**

1. Please complete Group Life Evidence of Insurability for coverage that is not guaranteed.
2. Return completed and signed form to your Benefits Office.

A. EMPLOYEE INFORMATION

First Name Middle Initial Last Name

Street Address		City	State	Zip Code
Date of Birth (Month, Day, Year)	Employee ID	Date of Employment	Salary	Gender ☐ Male ☐ Female

B. BASIC LIFE

Amount $ _____ Insurance Class: _____ Effective Date: _____

Location (check one): ☐ BCC ☐ Tax Collector ☐ Property Appraiser ☐ Clerk of Court

C. SUPPLEMENTAL LIFE

Employee Current Amount $_____	☐Increase ☐Decrease	Amount $_____	Grand Total $_____	Effective Date _____
Spouse Current Amount $_____	☐Increase ☐Decrease	Amount $_____	Grand Total $_____	Effective Date _____
Child Current Amount $_____	☐Increase ☐Decrease	Amount $_____	Grand Total $_____	Effective Date _____

D. SPOUSE INFORMATION

First Name Middle Initial Last Name

Date of Birth (Month, Day, Year)	Is your spouse also an employee covered under this plan? ☐ Yes ☐ No	Gender ☐ Male ☐ Female

E. CHILDREN INFORMATION – (List names and date of birth for your eligible children)

F. AUTHORIZATION

I authorize my employer to make these change(s) and to withdraw any premiums from my salary to pay for supplemental insurance coverage.

Employee Signature	Daytime Telephone Number	Evening Telephone Number	Date Signed