Life & Disability Insurance Benefit Enrollment Form

Return to: benefitforms@stlouiscountymn.gov by internal email only

NATIONAL INSURANCE SERVICES

Employer Name: **St. Louis County**			NIS Group Number: **012324**	
Full Name (Last name, First name, Middle Initial):			Date of Hire/Date status changed to Full time:	
Home Address:		City:	State:	Zip:
Employee ID #: (required)	☐ Single ☐ Married	US Citizen? ☐ Yes ☐ No	Date of Birth:	☐ Male ☐ Female
Occupation/Title:	Select One: ☐ St Louis County ☐ ARC ☐ CHB			☐ 37.5 hrs/wk ☐ 40.0 hrs/wk

Basic Life (You MUST Select ONE): ☐ Elect ☐ Decline ☐ No Change

Long Term Disability Insurance (You MUST Select ONE):
☐ Elect ☐ Decline/Cancel ☐ No Change

Short-Term Disability Insurance (You MUST Select ONE):
☐ Elect ☐ Decline/Cancel ☐ No Change

Employee Supplemental Life (You MUST Select ONE):

☐ Elect $ _____. Choose $10,000 increments up to $500,000 or six times your annual salary, whichever is less.
☐ Decline/Cancel
☐ Increase by $_____ or ☐ Decrease by $ _____. Choose $10,000 increments only.
☐ No Change

Spousal Supplemental Life (You MUST Select ONE):

☐ Elect $ _____. Choose $5,000 increments up to half of the amount employee has elected.
☐ Decline/Cancel
☐ Increase by $_____ or ☐ Decrease by $ _____. Choose $5,000 increments only.
☐ No Change
☐ Not Applicable, not married

Tip: Unless your spouse is newly eligible and you are electing $30,000 or less in coverage on your spouse, he/she will need to submit EOI (evidence of insurability), also known as the medical questionnaire and await approval.

Spouse's Name _____ Spouse's Date of Birth _____ Date of Marriage _____

Child Supplemental Life (You MUST Select ONE):

☐ Elect ☐ $10,000 ☐ $15,000 ☐ $20,000
☐ Decline/Cancel
☐ Increase/Decrease from $_____ to ☐ $10,000 ☐ $15,000 ☐ $20,000 in coverage
☐ No Change
☐ Not Applicable, no children

Child's Name _____ Child's Date of Birth _____ FT Student? ☐ Y ☐ N
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Child's Name _____ Child's Date of Birth _____ FT Student? ☐ Y ☐ N

☐ I have more children and have attached a sheet of paper to this application listing their names, dates of births and student status.

Is your covered spouse or any covered child employed by St. Louis County, ARC, or Community Health Board? ☐ Y ☐ N

For all elections made above, Medical Questions/Evidence of Insurability (posted at www.stlouiscountymn.gov/benefits) are required if you are electing more than the Guarantee Issue Amount and/or you are a late enrollee; requested coverage will be subject to approval.

I have been given the opportunity to apply for group insurance and agree to accept or decline coverage(s) as noted above. If I am declining coverage(s), I understand that if my dependents or I decide to apply for coverage at a later date, Evidence of Insurability (medical questions) may be required at my own expense and the insurance company must approve coverage. If I have elected any coverage(s) above, I authorize my employer to make any required deductions, if any, from my salary to pay my portion of the insurance premium when my insurance becomes effective. **Warning:** Any person who knowingly presents false information on an application for insurance may be guilty of a crime and subject to fines, confinement in prison, and/or denial of insurance benefits.

Signature:	Date:

Full Name:	Employer Name: **St. Louis County**	Date:

Enter your Life Insurance beneficiary information:

List the person(s) entitled to receive benefits in the event of your death.

Primary Beneficiary(ies) Attach additional pages if necessary.		
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
Secondary Beneficiary(ies) Attach additional pages if necessary.		
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit
Full Name:	Relationship to you:	% of Benefit

Spouse's Signature (Required ONLY if choosing a primary beneficiary other than your spouse. Under state law a beneficiary other than your spouse may not be honored unless your spouse signs below. Please consult with your legal advisor before making such a designation.)

Spouse's Name:	Signature:	Date:

Sign Here

Signature:	**Date:**

For Employer Use Only:

Annual Salary $ _____ Coverage Amount $ _____

Coverage Effective date or Eligibility Date _____

For Employer Use Only:

Annual Salary: Hourly Wage $ _____ x FTE or Prorate _____ x Hours/year $ _____ = _____

Premium: Annual Salary $ _____ x Age rate or fixed rate _____ /24 = $ _____

Date ___/___/___ Date Eligible ___/___/___ Class _____ Computed/Verified by _____