



Reliastar  
Life Insurance Company  
#67121-5 / ACCOUNT #0001

# Life Insurance Enrollment / Change Request

**Knox County Retirement & Pension Board**  
City-County Building, Rm# 371  
400 Main Street  
Knoxville, TN 37902-2409  
Phone: (865) 215-2323

## A. Transaction Information

Enrollment / Change  <input type="checkbox"/> New Employee  _____ <i>Date of Hire</i>  <input type="checkbox"/> Change  _____ <i>Effective Date</i>	Requested Coverage <input checked="" type="checkbox"/> Accidental Death & Dismemberment (AD&D) <small>(Automatic Enrollment--Paid by Employer)</small>  <input checked="" type="checkbox"/> Basic Life <small>(Automatic Enrollment--Paid by Employer)</small>  <input type="checkbox"/> Supplemental Life <small>(Paid by Employee) (MUST COMPLETE SECTION B)</small>  <input type="checkbox"/> Spouse Life \$10,000.00 <small>(Paid by Employee) (MUST COMPLETE SECTION C)</small>  <input type="checkbox"/> Dependent Child Life \$5,000.00 per child* <small>(Paid by Employee) (MUST COMPLETE SECTION C)</small>  <u>Important Note:</u> Based on the requirements of the Plan, you may have to submit Medical Evidence of Insurability. Please ask the Retirement Office for more details.	Eligibility for Change <u>Qualifying Event:</u>  <input type="checkbox"/> Marriage <i>Date:</i> _____ <small>(Attach copy of marriage certificate)</small>  <input type="checkbox"/> Divorce <i>Date:</i> _____ <small>(Attach copy of divorce decree)</small>  <input type="checkbox"/> Birth / Adoption  <input type="checkbox"/> Death of Spouse  <input type="checkbox"/> Death of Dependent  <input type="checkbox"/> Other: _____	Change  <input type="checkbox"/> Add Spouse Life <small>(COMPLETE SECTION C)</small>  <input type="checkbox"/> Remove Spouse Life <small>(COMPLETE SECTION C)</small>  <input type="checkbox"/> Add Dependent Child Life* <small>(COMPLETE SECTION C)</small>  <input type="checkbox"/> Remove Dependent Child Life* <small>(COMPLETE SECTION C)</small>  <input type="checkbox"/> Increase Employee Amount <small>(COMPLETE SECTION B)</small>  <input type="checkbox"/> Decrease Employee Amount <small>(COMPLETE SECTION B)</small>  <input type="checkbox"/> Change Beneficiary <small>(COMPLETE SECTION D)</small>
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## B. Employee Information – Please Print

Social Security Number	Employee Name	Date of Birth	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Telephone Numbers Home: Work: Cell:	Employee #
Employee Home Address (Number, Street, Apt. No., City, State, ZIP Code)				Department	
Employee Supplemental Coverage Amounts <input type="checkbox"/> NONE <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$45,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$75,000 <input type="checkbox"/> \$90,000 <input type="checkbox"/> \$105,000					

## C. Covered Spouse / Dependent – \* CHILDREN COVERED FROM AGE 15 DAYS TO AGE 26 YEARS.

(A)dd (R)emove	Relationship	Dependent Name	Social Security Number	Date of Birth	Spouse Life \$10,000 Coverage	Child Life* \$5,000 Coverage
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>

## D. Beneficiary Designation / Change – Spouse / Dependent coverage Beneficiary is always the Employee.

Beneficiary Name	Address (Number, Street, Apt. No., City, State, ZIP Code)	Social Security Number	(P)rimary or (C)ontingent	(%)	Relationship
				%	
				%	
				%	

Special Remarks

## E. Certification – Signatures Required

Any person who, knowingly with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading information concerning any fact material thereto commits a fraudulent act, which is a crime, and may subject such person to criminal and civil penalties, and denial of insurance benefits.

Employee Signature (Required)	Date	Received by Retirement Office (Required)	Date
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Retirement Office Only:  Approved  Declined, Reason: \_\_\_\_\_