

CURRENT PROVIDER:
Metropolitan Life
Insurance Company

Life Insurance Enrollment/Change Request

Group Report No.: 135807

Sub Division: 0001

Branch: 0001

Knox County Retirement & Pension Board
City-County Building, Rm. 371
400 Main Street
Knoxville, TN 37902-2409
(865) 215-2323 • (865) 215-2421 (fax)

A. Transaction Information

<p>1. Enrollment</p> <p><input type="checkbox"/> New Employee Date of Hire:</p> <p><input type="checkbox"/> Change Effective Date:</p>	<p>2. Requested Employee Coverage</p> <p><input checked="" type="checkbox"/> AD& D and Basic Life (Paid by Employer) (Accidental Death & Dismemberment & Basic)</p> <p><input type="checkbox"/> Supplemental Life (Paid by Employee) <i>(MUST COMPLETE SECTION B.8)</i></p>	<p>3a. Requested Dependent Coverage <i>(MUST COMPLETE SECTION C)</i></p> <p><input type="checkbox"/> Spouse Life \$10,000.00</p>	<p>4. Change <i>(MUST COMPLETE SECTION C)</i> (If necessary, provide explanation in Section D, Special Remarks.)</p> <p><input type="checkbox"/> Add Spouse <input type="checkbox"/> Remove Spouse <input type="checkbox"/> Add Child(ren) <input type="checkbox"/> Remove Child(ren)</p> <hr/> <p>Change <i>(MUST COMPLETE SECTION B8)</i></p> <p><input type="checkbox"/> Increase Employee Amount <input type="checkbox"/> Decrease Employee Amount</p> <hr/> <p>Change <i>(MUST COMPLETE SECTION D)</i></p> <p><input type="checkbox"/> Change Beneficiary</p>
<p>3b. Requested Dependent Coverage <i>(MUST COMPLETE SECTION C)</i></p> <p><input type="checkbox"/> Dependent Child Life \$5,000.00 per child</p>			

B. Employee Information – Please Print all Information

1. Emp. Soc. Sec. No.	2. Employee Name (Last, First, M.I.)	3. Birthdate (MM/DD/YYYY)	4. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	5. Telephone Numbers Home: () Work: ()	Employee No.
6. Employee Home Address (Number, Street, Apt. No., City, State, ZIP Code)				7. Dept./Occupation	
8. Employee Supplemental Coverage Amounts (Based on the requirements of the Plan, you may have to submit Medical Evidence of Insurability)					
<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(s) – MUST COMPLETE IF REQUESTING SPOUSE OR DEPENDENT CHILD COVERAGE

Check this box if you are refusing coverage for your dependents.

(A)dd/New (C)hange (R)emove	Relationship	Dependent Name (First, Middle Initial, Last)	Social Security Number (If dependent has no SSN, write "None")	Birth date MM / DD / YYYY	Spouse \$10,000 of Coverage	Child* \$5,000 of Coverage	Is Child a Full Time Student?	
							Yes	No
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. Beneficiary Designation/Change – If more space needed use "Special Remarks" below. Dependent coverage Beneficiary is always the Employee.

Name	Address (Number, Street, Apt. No., City, State, ZIP Code)	Social Security No.	Type P = Primary C = Contingent	Percent	Relationship

Special Remarks ** Children covered from age 14 days to age 19 years, or 25 years if full time student.*

E. Certification – Signatures Required

Employee Signature <i>(Required)</i>	Date	Employer Signature <i>(Required)</i>	Date
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