

Mark all boxes and complete all sections that apply. Return completed form to your Employee Benefits Office at the City of Fort Lauderdale, 101 NE 3<sup>rd</sup> Ave, Ste 300, Ft. Lauderdale, FL 33301.

<b>APPLICANT</b>	Your Name (Last, First, Middle)		Group Name <b>The City of Fort Lauderdale</b>		Group Number(s) <b>142195</b>																																																		
	Your Address		City		State	ZIP																																																	
	Your Soc. Sec. No.	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female		Job Title/Occupation																																																		
<b>LIFE</b>	<p><i>Check with your Employee Benefits Office about coverage options available to you and Evidence Of Insurability requirements.</i></p> <p><b>Life Insurance</b>                  You may choose one from the following Life with AD&amp;D options:  <input type="checkbox"/> \$10,000   <input type="checkbox"/> \$25,000   <input type="checkbox"/> \$50,000   <input type="checkbox"/> \$100,000   <input type="checkbox"/> \$150,000   <input type="checkbox"/> Decline Life Insurance with AD&amp;D options</p> <p><b>Dependents Life Insurance</b>  <input type="checkbox"/> Spouse requested amount \$ _____   <input type="checkbox"/> Decline Spouse Life Insurance                  Spouse Name _____ Date of Birth _____  <input type="checkbox"/> Child(ren)   <input type="checkbox"/> Decline Child(ren) Life Insurance</p>																																																						
	<p><i>This designation applies to Life/Life with AD&amp;D Insurance available through your Employer, if any. Designations are not valid unless signed, dated, and delivered to the Employer during your lifetime. See page 2 for further information.</i></p> <table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:30%;">Primary - Full Name</th> <th style="width:30%;">Address</th> <th style="width:15%;">Soc. Sec. No.</th> <th style="width:10%;">Relationship</th> <th style="width:15%;">% of Benefit</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr> <th>Contingent - Full Name</th> <th>Address</th> <th>Soc. Sec. No.</th> <th>Relationship</th> <th>% of Benefit</th> </tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>						Primary - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit																					Contingent - Full Name	Address	Soc. Sec. No.	Relationship	% of Benefit																			
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<b>CHANGE</b>	<p><i>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</i></p> <p><input type="checkbox"/> Add Dependent   <input type="checkbox"/> Delete Dependent   <input type="checkbox"/> Name Change   <input type="checkbox"/> Beneficiary Change                  Date of add/delete _____   Former name _____   <input type="checkbox"/> Other _____</p>																																																						
	<p><b>SIGNATURE</b></p> <p>I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. If declining coverage, I understand that if I want to become insured later, I will be required to provide The Standard with satisfactory Evidence Of Insurability, and that The Standard will have the right to refuse my request for insurance. I understand that coverage(s) not specifically elected will not become effective, even if not marked as declined above.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:60%;">Member/Employee Signature Required</td> <td>Date (Mo/Day/Yr)</td> </tr> </table>						Member/Employee Signature Required	Date (Mo/Day/Yr)																																															
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## Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, “Dorothy Q. Smith, Trustee under the trust agreement dated \_\_\_\_\_.”
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have any questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer’s coverage under the Group Policy.