Correction Officers Benevolent Association Supplemental Life Insurance- Employee Enrollment

Name (Last, First, Middle)	*Date of Birth*	*Social Security Number*	*Gender*
Address	*City*	*State*	*Zip*
Date of Appointment	*Date of Retirement (If Applicable)*		

Dependent Information

Spouse

Name (Last, First, Middle)	*Gender*	*Date of Birth*

Child

Name (Last, First, Middle)	*Gender*	*Date of Birth*

Basic Life Amount (Mark Coverage Amount)

Employee	Spouse	Child
☐ $15,000	☐ $15,000	☐ $5,000

Employee Supplemental Life Amount (Mark Coverage Amount)

			New Election*
☐ $50,000	☐ $100,000	☐ $200,000	☐

Spouse Supplemental Life Amount (Mark Coverage Amount)

			New Election*
☐ $25,000	☐ $50,000	☐ $100,000	☐

Primary Beneficiary

Full Name	Address	Relationship	% Benefit

Contingent Beneficiary

Full Name	Address	Relationship	% Benefit

If electing coverage, I authorize from my wages to cover contributions, if required, toward the cost of insurance. I understand that my deduction amount will change or costs change.

Signature ____ Date ___________________

*Only $50,000 will be effective immediately. Additional coverage will not be effective until you receive written approval. For a new election greater than $50,000, please complete and submit a Medical History Statement.