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DEPENDENT INSURANCE

Use this form if:

1. You had no dependents when you were first eligible for coverage and are now acquiring your first eligible dependent; or,
2. You have Dependent Plan A coverage and are acquiring a spouse and would like to increase your coverage to Dependent Plan B.

In all other cases, evidence of insurability is required to obtain Dependent Plan A or B coverage. This form must be completed, signed and received by your employing office within 31 days of the qualifying event.

A spouse or child already insured under the Group Life Insurance Program as an employee or retiree cannot be insured as a dependent of a participant. If both parents of a child are insured under the Program, only one parent may purchase dependent coverage for that child. Stepchildren may not be covered as dependents.

Your Name:
(Prefix) (First) (MI) (Last) (Suffix)

Social Security Number: Date of Birth:
(mm) (dd) (yyyy)

Mailing Address:
(Street/PO Box) (City/Town) (State) (ZIP)

Employer Location Code: Employer Location Name:

Eligible Event: Event Date:
(Marriage, Birth, Adoption, etc.) (mm) (dd) (yyyy)

Complete this information if dependent is your spouse.

Spouse's Name:
(Prefix) (First) (MI) (Last) (Suffix)

Social Security Number:

I am electing to purchase:

PLAN A: Spouse \$ 5,000
 Full-time, unmarried student to age 22 \$ 5,000
 Children, 6 months to age 19 \$ 5,000
 Children, 0 to 6 months \$ 1,000

PLAN B: Spouse \$10,000
 Full-time, unmarried student to age 22 \$ 5,000
 Children, 6 months to age 19 \$ 5,000
 Children, 0 to 6 months \$ 2,500

Convert to DEPENDENT PLAN B due to Marriage

Employee Signature: _____ Date: _____