ReliaStar Life Insurance Company #67121-5 Account #0002	Knox County Schools 912 S. Gay Street / P.O. Box 2188 Knoxville, TN 37901-2188	**Life Insurance Enrollment/Change Request Form**	ING

A. Transaction Information

1. ENROLLMENT DATE OF HIRE:	2. Reason for Enrollment/Change: ☐ New Employee/First Time Eligible ☐ Open Enrollment ☐ Qualifying Event:/Family Status Change Event:_____	3. Requested Employee Coverage ☒ Basic Life (Paid by Employer) ☐ Supplemental Life (Paid by Employee) ***(Must complete Section B.9)***	5. Change ***(Must complete Section C)*** ☐ Add Spouse ☐ Remove Spouse ☐ Add Child(ren) ☐ Remove Child(ren)
☐ Change Effective Date:	Date:_____	4. Requested Dependent Coverage ***(Must complete Section C)***	Change ***(Must complete Section B.9)*** ☐ Increase Employee Amount ☐ Decrease Employee Amount
	☐ Late Enrollee/Statement of Health ☐ Other_____	☐ Spouse Life- $10,000.00 ☐ Dependent Child Life-$5,000.00 per child	Change ***(Must complete Section D and/ or E)*** ☐ Change Beneficiary(ies)

B. Employee Information – Please Print all Information in Ink

1. Emp. Soc. Sec. No.	2. Employee Name (Last, First, M.I.)	3. Birth Date (MM/DD/YYYY)	4. Age	5. Sex ☐ M ☐ F	6. Job /Position

7. Employee Mailing Address (Number, Street, Apt. No., PO Box, City, State, ZIP Code)	8. Telephone Numbers Home: ( ) Work or Cell: ( )

9. Employee Supplemental Coverage Amounts (Based on the requirements of the Plan, you may have to submit Medical Evidence of Insurability)

☐ NONE ☐ $20,000 ☐ $30,000 ☐ $45,000 ☐ $60,000 ☐ $75,000 ☐ $90,000 ☐ $105,000

C. Covered Spouse/Dependent(s) – *Must complete if requesting Spouse or Dependent Child Coverage.* *Children covered from age 15 days to 26 years

(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
					☐	☐
					☐	☐
					☐	☐

D. Primary Beneficiary Designation/Change – *For Dependent coverage Beneficiary is always the Employee.*

Name	Relationship	Social Security No.	Address (Number, Street, Apt. No., PO Box, City, State, ZIP Code)	Percent
Payment will be made in equal shares or all to the survivor unless otherwise indicated.		**TOTAL MUST EQUAL:**		**100%**

E. Contingent Beneficiary Designation/Change

Name	Relationship	Social Security No.	Address (Number, Street, Apt. No., PO Box, City, State, ZIP Code)	Percent
Payment will be made in equal shares or all to the survivor unless otherwise indicated.		**TOTAL MUST EQUAL:**		**100%**

CERTIFICATION – READ THIS INFORMATION CAREFULLY - SIGNATURE 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	KCS	# OF PAY PERIODS / EMPLOYEE NUMBER