GROUP EMPLOYER LIFE INSURANCE: ENROLLMENT AND BENEFICIARY DESIGNATION FORM

See the opposite side of this form for a list of eligible bargaining units. Not all employees are eligible for this benefit.

A. TYPE OF TRANSACTION

☐ New Hire ☐ Change Beneficiary ☐ Rehire/Reinstatement

B. EMPLOYER INFORMATION

Employer Name	Employer Address	Control Number
City & County of San Francisco	**1145 Market Street, 3rd Floor, San Francisco, CA 94103**	**839201**

C. EMPLOYEE INFORMATION

Last Name	First Name	Initial

Home Address	City	State	Zip Code

Social Security Number	DSW	Birth Date MM/DD/YYYY

Email Address	Home/Cell Telephone Number	Work Telephone Number

D. PRIMARY BENEFICIARY DESIGNATION

Your beneficiary is the person or persons who may benefit from your life insurance policy in the event of your death. You should name at least one primary beneficiary. If more than one primary beneficiary is named, the primary beneficiaries share equally unless otherwise indicated below. Enter the full legal name (Mary. J. Smith, not Mrs. Smith). If a trustee is named as beneficiary, enter the name and date of the trust, and the name and address of the trustee. For example: The John J. Smith Revocable Life Insurance Trust, January 1, 1994, John Smith – Trustee, 123 Apple Lane, City, State, 00000.

Beneficiary Last Name	Beneficiary First Name	Social Security Number	Relationship	Percentage

E. CONTINGENT BENEFICIARY DESIGNATION

Contingent beneficiaries will only be eligible to benefit if all primary beneficiaries have predeceased the insured employee. If more than one contingent beneficiary is named, the contingent beneficiaries share equally unless otherwise indicated below. Enter the beneficiary's full legal name.

Beneficiary Last Name	Beneficiary First Name	Social Security Number	Relationship	Percentage

F. SPOUSAL CONSENT FOR ALTERNATE BENEFICIARY

If you name someone other than your spouse as a beneficiary, it is recommended that your spouse sign this optional consent, which allows the spouse to waive rights to any community property interest in this benefit.

I am aware that my spouse, the employee named above, has designated someone other than me as the beneficiary of group life insurance under the policy listed above. I consent to this designation and waive any rights I have have to the proceeds of this insurance under applicable community property laws. I understand this consent and waiver supercedes any prior consent or waiver under this plan.

Spouse signature: _____ Date: _____

G. CERTIFICATION: EMPLOYEE SIGNATURE REQUIRED

My signature below signifies my agreement with the statements and authorization under Certificate and Authoriziation on the back of this form.

Employee signature: _____ Date: _____

Mail or drop off this form in person to: SFHSS, 1145 Market Street, 3rd Floor, San Francisco, CA 94103 • SFHSS Member Services Phone: (628) 652-4700
Fax forms to: (628) 652-4701 • Please do not fax the same form multiple times. • **Keep a copy of this form for your records.**

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The bargaining units listed below are eligible for employer-paid group life insurance.

City and County Employees	Municipal Attorneys Association	$150,000 group life insurance coverage
	IFPTE Local 21 TWU Local 200 SEAM SEIU Local 1021 Teamsters Local 856 Multi-Unit Municipal Executives (MEA)	$50,000 group life insurance coverage
Superior Court Employees	Court Attorneys 311C, 312C, 316C	$125,000 group life insurance coverage
	Court Reporters Court Local 21 Municipal Executives (MEA) Unrepresented Professionals	$50,000 group life insurance coverage
	Court SEIU Court Interpreters	$25,000 group life insurance coverage

Leaves of Absence	If you are not actively at work due to a temporary lay-off, personal leave, family care leave, or administrative leave (non-medical reasons), your coverage will terminate at the end of the month following the month your absence started. If you are not actively at work due to illness or injury, your life insurance coverage will continue for 18 months from the start of your medical leave. After six months, you may qualify for a further extension of your life insurance benefits (Permanent and Total Disability Benefit); however, you must provide the life insurance administrator with a written notice of claim for this extended benefits within the 18 month coverage period. Call SFHSS at **(628) 652-4700** for information about how a leave of absence can impact your life insurance coverage.
Misrepresentations	For your protection California law requires this notice. Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison, and substantial civil penalties.
Certification and Authorization	By signing this form, you certify that all information on this form is true and complete to the best of your knowledge and belief. You understand that this insurance is subject to all of the terms of the Plan of Insurance contained in the group policy and summarized in the announcement materials made available to me. You understand that the effective date of insurance for myself is subject to my being actively at work on that date. You understand that, in the event you fail to sign this form within 31 days of the effective date of eligibility or if for any reason the life insurance administrator does not receive notice of enrollment or a change of beneficiary within a reasonable time following the event, eligibility may be affected. You understand that your employer will arrange for the issuance of this Group Life Coverage if you are eligible.
Conditions	Unless otherwise expressly provided in the form designating a beneficiary, if any named beneficiary predeceases you, the life proceeds shall be payable equally to the remaining named beneficiary or beneficiaries. If no named beneficiary survives you, any sum becoming payable under the group policy by reason of your death shall be payable as prescribed in the group policy. If the designation of beneficiary provides for payment to a trustee under a trust agreement, the life insurance administrator shall not be obliged to inquire in the terms of the trust agreement and shall not be chargeable with knowledge of the terms. Payment to and receipt by the trustee shall fully discharge all liability of the insurance company.
Beneficiary Designation Instructions	When two or more beneficiaries are named, and they are not to share the benefits equally, enter the percentage each beneficiary is to receive on the form in the space provided. Dollars and cents should not be specified. When added together the sum of percentages going to two or more beneficiaries should total 100%. A contingent beneficiary will receive benefits only if the primary beneficiary(ies) do not survived the insured. If naming more than one contingent beneficiary at 100% each, please indicate 1st contingent, 2nd contingent, 3rd contingent, etc.
Filing a Life Insurance Claim	In the event of the insured employee's death, the beneficiary should immediately contact SFHSS by calling **(628) 652-4700** or (**800) 541-2266**. SFHSS will provide assistance and information regarding filing the life insurance claim. For more details about filing a life insurance claim, including claim filing deadlines, read the complete life insurance policy available on **sfhss.org**. A printed copy is available upon request.
Plan Administrator	As of the date of this form the Health Service System of the City & County of San Francisco is currently contracted with the insurer The Hartford to provide employer-sponsored group life insurance to the employees who are eligible based on their bargaining unit agreements.