COUNTY PAID LIFE INSURANCE POLICY

(PLEASE PRINT OR TYPE)

Employee's Name: _____

Social Security #: _____ Date of Birth: _____ M ☐ F ☐

I HEREBY DESIGNATE AS BENEFICIARY OF ALL MONIES PAYABLE UPON MY DEATH

_____

(Last Name) (Full Given Name) (Relationship)

I HEREBY APPLY FOR INSURANCE UNDER GROUP POLICY ISSUED THROUGH THE COUNTY OF CHAMPAIGN WITH THE LIFE INSURANCE CHOSEN BY THE COUNTY, SUBJECT TO ALL TERMS, CONDITIONS, AND PROVISIONS OF SAID POLICY.

_____ _____

(Date) (Employee Signature in Ink)

FOR OFFICE USE ONLY

Dept. _____ Eff. Date _____ Union _____ Health Plan _____