

**GROUP TERM LIFE INSURANCE ENROLLMENT FORM**

Please use this form to apply for coverage. Simply fill in any requested information below. Don't forget to include your Social Security Number, herein shown as SSN, Birthdate, sign your name and enter today's date.



Return completed form to: Benefits Department

**EMPLOYER: Bi-State Development Agency**

**ALL ABOUT YOU – THE EMPLOYEE**

Your Name \_\_\_\_\_ SSN \_\_\_\_\_ Date of birth \_\_\_\_\_  
 Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Email \_\_\_\_\_ Home/Cell Phone \_\_\_\_\_ Employee ID # \_\_\_\_\_ Gender: \_\_\_\_\_

**COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE**

I am currently married and my date of marriage is \_\_\_\_\_  
 Spouse Name \_\_\_\_\_ SSN \_\_\_\_\_ Date of birth \_\_\_\_\_ Gender \_\_\_\_\_

**YOUR COVERAGE ELECTIONS**

View the Summary of Benefits for costs and instructions for how to calculate premium.

**Employee-Paid Term Life Insurance – Policy # FLX0970854 Underwritten by LINA**

Choose your desired coverage amount below and who you would like to cover. See the Summary of Benefits for costs.

Who You Want to Cover	Coverage Amount	Accept your desired coverage amount or decline coverage below.
<input type="checkbox"/> Employee	0.5, 1 or 2 times annual compensation up to \$600,000 Guaranteed Issue Amount***: The lesser of 2 times annual compensation or \$400,000	<input type="checkbox"/> 0.5 times your annual compensation <input type="checkbox"/> 1 times your annual compensation <input type="checkbox"/> 2 times your annual compensation <input type="checkbox"/> Decline Coverage
<input type="checkbox"/> Spouse (Spouse Option must correlate with Child Option)	<input type="checkbox"/> Option 1 - \$10,000 <input type="checkbox"/> Option 2 - \$20,000 <input type="checkbox"/> Option 3 - \$25,000**** Guaranteed Issue Amount***: \$25,000	<input type="checkbox"/> Decline Coverage
<input type="checkbox"/> Children (Child Option must correlate with Spouse Option)	<input type="checkbox"/> Option 1 - \$2,500 <input type="checkbox"/> Option 2 - \$5,000 <input type="checkbox"/> Option 3 - \$7,000**** Guaranteed Issue Amount***: All amounts	<input type="checkbox"/> Decline Coverage

If Children are elected, all eligible dependent children will be covered.

\*\*\* Guaranteed Issue Amount is only available if enrolling within the first 31 days of eligibility. Amounts of insurance may be limited by state law.

\*\*\*\*This is the maximum coverage amount that you can choose under this plan. Coverage elected during this enrollment period will take effect on the later of 01/01/2026, or the date your election form is received by your Employer.

## SIGN TO ACCEPT DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. I understand that coverage is subject to the insurance company's approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

**Caution:** Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act.

**Please Sign Here**  Signature \_\_\_\_\_ Date \_\_\_\_\_

Created on 09/2025.