GROUP OPTIONAL LIFE INSURANCE APPLICATION

Dallas County Group #681714

Evidence of Insurability (EOI) will be mailed to you directly from The Hartford

Important
Please submit this form to:
benefits@dallascounty.org
214-653-7636- Fax Number

PLEASE PRINT	**DEADLINE NOVEMBER 1, 2024**	**EFFECTIVE PLAN YEAR 2025**	
Last Name	First	M.I.	Sex ☐ M ☐ F
Home Address		Apartment/Unit	
City	State	ZIP	
Home Phone	Salary $ ☐ Annual ☐ Month ☐ Hour		
Date of Birth	Social Security No.	Date of Hire	
Email address personal or Dallas County			

Are you applying as a newly-hired employee?	YES ☐ NO ☐	Spouse Optional Life (SLF) – Evidence of Insurability is required for coverage amounts greater than $25,000.
Are you applying during annual enrollment?	YES ☐ NO ☐	Complete this form ONLY if adding coverage or increasing current coverage level - Evidence of Insurability is required.
Are you applying mid-year due to a qualified change in status event?	YES ☐ NO ☐	Refer to the instructions on the back of this form. Event Date:

Please include Employee ID#_____

SELECT OPTIONAL TERM LIFE **REFER TO ENROLLMENT GUIDE OR RATE SHEET FOR APPLICABLE COST INFORMATION**

Employee Optional Term Life and AD&D (TLF)	**Spouse Optional Term Life (SLF) – AD&D not available**	
Evidence of Insurability (EOI) is required to add or increase TLF coverage (example - from 1 to 2 times salary). EOI is not required for a newly-hired employee enrolling during the new-hire initial enrollment period.	Evidence of Insurability (EOI) is required to add or increase SLF coverage. EOI is not required for a newly-hired employee enrolling during the new-hire initial enrollment period and for $10,000 or $25,000 levels only.	
	Spouse Name	**Spouse Date of Birth** __/__/__ **Sex** __**Male** ___**Female**
Maximum TLF $400,000 - Includes AD&D at 1 x TLF amount.	**SLF amount cannot exceed 50% of employee TLF amount.**	
☐ 1/2 times annual salary	☐ $10,000	☐ $25,000
☐ 1 times annual salary	☐ $50,000	☐ $75,000
☐ 2 times annual salary	☐ $100,000	
☐ I do not apply (newly-hired employee only)	☐ I do not apply (newly-hired employee only)	

SELECT DEPENDENT GROUP TERM LIFE (DGL)

Select either DGL or SLF or both. Monthly cost shown is for one or more children.

OPTION 1	**I apply**	YES ☐ NO ☐	**OPTION 2**	**I apply**	YES ☐ NO ☐
	Spouse $5,000	Children $2,500		Spouse $10,000	Children $5,000
	Monthly Cost	$1.05		Monthly Cost	$2.10

BENEFICIARY DESIGNATION

If you are adding new coverage or wish to change existing beneficiaries, please visit mybenefits.thehartford.com. If you are enrolling in Spouse Optional Term Life (SLF), the employee is the designated beneficiary. An EOI will be emailed to you if provided. If not please watch your mail for a letter from The Hartford. The Hartford will contact you if they need additional information.

This is an application to increase life insurance only. If approved by the Hartford Underwriting , Dallas County will deduct premiums in the first full month after the approval is received. By signing this Application, I certify the information on this form is true and correct. I understand and agree that any incorrect statements material to the risk and knowingly made by me in this application will invalidate my coverage(s) and that all statements made by me shall be deemed representations and not warranties. I authorize my Employer to deduct from my wages or salary my portion, if any, of the premiums as they become due. I agree that my Employer acts as my agent in all dealings herein and my coverage(s) are subject to any future amendments to the Contract(s)/Policy(ies). I understand that I must be Actively at Work on the effective date of my coverage.

Employee Signature _____ Date: _____