LONG BEACH COMMUNITY COLLEGE DISTRICT
TERM LIFE and AD&D INSURANCE ENROLLMENT/
BENEFICIARY CHANGE FORM
(EMPLOYER PAID)

LONG BEACH CITY COLLEGE

❑ New Enrollee ❑ Re-hire ❑ Re-enrollment ❑ Beneficiary Change Event Date: Effective Date:

EMPLOYEE INFORMATION (Please Print)

First Name | Last Name | SSN | Date of Birth | Date of Hire

Address | City | State | Zip Code | $ Annual Salary

Job Title

Marital status: ❑ Single ❑ Married (Spouse) ❑ Married (D.P.) ❑ Divorced Sex: ❑ M ❑ F

Employment Status: ❑ Hourly ❑ Salary ❑ Classified ❑ Executive

BASIC LIFE AND AD&D - Anthem Blue Cross and Unum

☒ Paid 100% by LBCCD .....

$25,000 (Anthem Blue Cross) and $75,000 (Unum) = $100,000 Basic Life & AD&D Benefit provided by LBCCD

Total Basic Life and AD&D Benefit Amount: $100,000

BENEFICIARY EMPLOYEE LIFE DESIGNATION

Primary Beneficiary - First to receive payment (required) If more than one beneficiary is names, enter a percentage (%) for each.

❑ **Named individuals (Enter the name, address, date of birth, social security number and relationship to the insured for each name listed.)**

Please indicate a primary Basic Life and AD&D beneficiary below. Surviving beneficiaries will be paid equally unless otherwise indicated.

Beneficiary Name (Last, First)	Address	Date of Birth	Social Security no.	Relationship	%

❑ Estate of Insured

❑ Revocable or Irrevocable Trust (Enter the name of the Trustee, name of Trust and complete date of Trust.)

❑ Trustee Under Insured's Will (if choosing this option DO NOT enter additional names in the Primary Beneficiary field.)

Secondary Beneficiary - Second to receive payment (optional) If more than one beneficiary is names, enter a percentage (%) for each.

❑ **Named individuals (Enter the name, address, date of birth, social security number and relationship to the insured for each name listed.)**

Please designate a secondary Basic Life and AD&D beneficiary below if your primary beneficiary(ies) are not living at the time of your benefit payout.

Beneficiary Name (Last, First)	Address	Date of Birth	Social Security no.	Relationship	%

❑ Estate of Insured

❑ Revocable or Irrevocable Trust (Enter the name of the Trustee, name of Trust and complete date of Trust.)

❑ Trustee Under Insured's Will (if choosing this option DO NOT enter additional names in the Primary Beneficiary field.)

EMPLOYEE AUTHORIZATION (Signature required)

Anthem Blue Cross Health Plan Arbitration Agreement:

I hereby apply for the insurance for which I am now or may become eligible under the group policy or policies issues to the policyholder by Anthem Blue Cross Life and Health Insurance Company. I hereby authorize the deduction from my earnings of the required contribution, if any, toward the cost of such insurance, which authorization may be revoked by me at any time by prior written notice to the policyholder. I understand that if my employment is terminated, upon re-employment, insurance will not become effective until I again apply for insurance in accordance with the terms of the group policy. To the best of my knowledge and belief, the information I have provided on this form is complete and correct.

Signature required for Anthem Blue Cross Plans **Date**

Unum Request for Signature and Certification:

I understand that my coverage may be subject to exclusions, limitations, delayed effective dates and benefit offsets, as described in the enrollment materials or employee booklet(s) that have been provided to me by my employer. I certify that all statements are true to the best of my knowledge and belief.

Signature Required for Unum **Date**