Optional Dependent Term Life Insurance
Enrollment/Cancellation Form

MCPS Form 450-2
November 2017

Employee and Retiree Service Center (ERSC) • Rockville, Maryland
MONTGOMERY COUNTY PUBLIC SCHOOLS

INSTRUCTIONS: Complete, sign electronically or manually, and return to the Employee and Retiree Service Center (ERSC). You may fax the signed form to 301-279-3651 or 301-279-3642, or e-mail a PDF of the signed form to ERSC@mcpsmd.org. Spouse must provide proof of insurability and be approved for coverage by the insurer. ERSC will initiate the process of providing evidence of insurability upon receipt of this form. Please include a copy of a marriage certificate (when enrolling a spouse) or birth certificate/birth registration (when enrolling a child).

PART I: EMPLOYEE INFORMATION—Please Print.

Name:	**Employee ID:**
Last Four Digits of SSN: ____ ____ ____ ____	**Home Phone:**

PART II: OPTIONAL DEPENDENT TERM LIFE INSURANCE DETAILS

You must be enrolled in Basic Employee Term Life Insurance to elect Optional Dependent Term Life Insurance.

Coverage amount is $10,000 for each qualified dependent spouse and/or dependent child(ren). The employee is the beneficiary.

Rates: 12-month biweekly payroll deduction = $1.15   10-month biweekly payroll deduction = $1.50

Coverage for qualified dependent children will continue until September 30th following their 23rd birthday. Be sure to notify ERSC once your youngest child has reached age 23 to have him/her removed from coverage and your deductions reduced accordingly.

PART III: FORM SUBMISSION REASON *(select one)*:

☐ **Cancel (anytime)**   ☐ **Qualifying Event***

*Qualifying event such as marriage or birth of a child. Supporting documentation required.

PART IV: COVERED DEPENDENTS:
I elect Optional Dependent Term Life Insurance for the following dependents: (Please print clearly)
List additional names on an attached blank form.

Add	Drop		Address:	Phone:
		Name:	**Address:**	**Phone:**
		Relationship:		**DOB:**
		Name:	**Address:**	**Phone:**
		Relationship:		**DOB:**
		Name:	**Address:**	**Phone:**
		Relationship:		**DOB:**
		Name:	**Address:**	**Phone:**
		Relationship:		**DOB:**
		Name:	**Address:**	**Phone:**
		Relationship:		**DOB:**

PART V: SIGNATURE

I am enrolling in optional dependent term life coverage, and I authorize MCPS to deduct the biweekly payroll deduction from my earnings until further notice. My contributions for insurance are under a contract issued by Voya Financial. I further understand that I am responsible for 100 percent of the premium for this optional coverage. I declare the statement above is true and understand this is the basis for determining the biweekly payroll deduction for coverage.

I understand that my electronic submission of this form and my electronic signature are intended to be, constitute, and are equivalent to my personal signature.

Signature *(Required)* _____ Date____/____/_____