



595 Stewart Avenue, 7th Floor, Garden City, NY 11530
(516) 247-5847 • FAX#: (516) 247-1352 • WWW.BBROWN.COM

SACHEM CSD- TEACHERS ASSOCIATION LIFE INSURANCE

ENROLLMENT / CHANGE FORM

Type of Coverage: (where applicable)	<input type="checkbox"/> Contributory Life & AD&D	<input type="checkbox"/> Dependent Life	
Contribution Type:	Contributory Only Options: <input type="checkbox"/> \$10,000, <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$50,000, <input type="checkbox"/> \$100,000	Contributory Only \$5,000-Spouse/\$1,000-each child	
<input type="checkbox"/> New Hire		<input type="checkbox"/> Late Enrollee <input type="checkbox"/> Rehire	(Official Use Only)
<input type="checkbox"/> Change Enrollment / Beneficiary	<input type="checkbox"/> New Address	<input type="checkbox"/> Name Change, previous Name:	Effective Date:
<input type="checkbox"/> Cancel Spouse/Partner and/or Dependent			

A. Employee Information

Name (Last, First)	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth:
Street Address	Date of F/T Hire	
City	State	Zip
Social Security No.	Hours worked per week	
Job Title	Annual Salary \$	
Marital Status	Home Phone	Work Phone
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated		

B. Dependent Coverage (If more space is needed, attach extra copies)

Spouse/Partner's Name (Last, First)	Date of Birth	Gender	Request to	Reason
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
Child's Name (Last, First)	Date of Birth	Gender	Request to	Reason
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	
		<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Add <input type="checkbox"/> Cancel	

C. Beneficiaries for Life, AD&D

☐ Add Beneficiary ☐ Change existing beneficiary to individual(s) below: (if more space is needed, attach extra copies.)

Name (Last, First)	Social Security No.	Benefit %	Relationship
Name (Last, First)	Social Security No.	Benefit %	Relationship
Name (Last, First)	Social Security No.	Benefit %	Relationship
Contingent Beneficiary(ies): If the beneficiary(ies) above are not living, then pay:			
Name (Last, First)	Social Security No.	Benefit %	Relationship
Name (Last, First)	Social Security No.	Benefit %	Relationship

If more than one beneficiary is named, the death benefit, unless otherwise provided herein, will be paid in equal shares to the designated beneficiaries who survive the employee. If no such beneficiary survives, payment will be made in accordance with the terms of the policy.

D. Participation/Waiver

☐ **Request to Participate:** I hereby request the policyholder to arrange the issuance of group insurance to which I am entitled, or to which I may be entitled, and I authorize my employer to make the periodic deductions from my earnings as my contributions toward the cost of insurance, if applicable.

☐ **Waiver of Insurance:** I do not wish to participate in this insurance program offered through my employer, and I understand that evidence of insurability satisfactory to the insurance company may be required to participate in the plan at a later date.

Reason for refusing: ☐ Not Interested ☐ Other, please specify:

The information provided above is true and complete to the best of my knowledge and belief.

Employee Signature: _____

Date: _____

Employer Representative: _____

Date: _____