



# Optional Dependent Term Life Insurance Enrollment/Cancellation Form

MCPS Form 450-2  
August 2014

Employee and Retiree Service Center (ERSC)  
MONTGOMERY COUNTY PUBLIC SCHOOLS

**INSTRUCTIONS:** Complete, sign, and return this form to the Employee and Retiree Service Center (ERSC). You may fax this form to 301-279-3642 or 301-279-3651 or e-mail an electronically signed Adobe PDF file to ERSC@mcpsmd.org. If you elect not to enroll within 60 days following employment, then you must wait for a future open enrollment. 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. You must provide proof of eligibility for all dependents.

**PART I: EMPLOYEE INFORMATION**—Please Print.

Name: _____		Employee ID: 0000 _____
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):**

- New Employee     Open Enrollment     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
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.

Signature (Required) \_\_\_\_\_ Date \_\_\_\_\_