RETIREE

Fulton County, Georgia

Group Dependent Life Insurance Enrollment

LAST NAME	FIRST NAME	MI	SEX	DATE OF BIRTH

Coverage Selection:

(Check Only One Dependent Life Option)

_____ Dependent Life $10,000 per dependent $2.89 per month

Eligible Dependent: (Spouse or Child up to age 26)

DEPENDENT NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER

I HEREBY REQUEST TO BE INSUREED AND AUTHORIZE DEDUCTIONS, IF ANY, FOR MY SHARE OF THE COST OF THE BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE GROUP POLICY (IES) ISSUED TO THE EMPLOYER LISTED ABOVE. FOR THOSE COVERAGES I HAVE DECLINED, I UNDERSTAND THAT IF I CHOOSE TO ENROLLAT A LATER DATE, MY COST MAY BE HIGHER AND A HEALTH QUESTIONARIRE MAY BE REQUIRED. I UNDERSTAND THAT ANY INDIVIDUAL DEPENDENT CAN ONLY BE COVERED ONCE IN THIS GROUP LIFE INSURANCE PLAN.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act which is a crime and subjects such person to criminal and civil penalties. INFORMATION ON THIS FORM WILL OVERRIDE ANY PRIOR SELECTION OR DESIGNATION FOR THE POLICY (IES) LISTED ABOVE.

RETIREE SIGNATURE _____ DATE _____ /_____/_____