

<b>Optional Dependent Term Life Insurance ENROLLMENT / CANCELLATION FORM</b>	<b>Employee and Retiree Service Center (ERSC) Montgomery County Public Schools 7361 Calhoun Place, Suite 190 Rockville, Maryland 20855</b>
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**INSTRUCTIONS:** Complete, sign, and return to the Employee and Retiree Service Center (ERSC). You may fax this form to 301-279-3642 / 301-279-3651. If you elect not to enroll within 60 days following employment, then you must wait for a future open enrollment. You must provide proof of eligibility for all dependents.

**PART I: EMPLOYEE INFORMATION (PLEASE PRINT)**

Name:	Last Four Digits of SSN:	Employee ID: 0000 _____
E-mail:	Home Phone:	

**PART II: OPTIONAL DEPENDENT TERM LIFE**

You must be enrolled in Basic Employee Term Life coverage to elect Optional Dependent Term Life coverage.  
**Coverage amount is \$10,000 for each qualified dependent spouse and/or dependent child(ren). The employee is the beneficiary.**  
 Rates: 12-month bi-weekly payroll deduction = \$1.30                      10-month bi-weekly payroll deduction = \$1.69  
 Coverage for qualified dependent children will continue until September 30th following their 23rd birthday.

You must select one of the following reasons for your enrollment:

**New Employee**    
  **Open Enrollment**    
  **Cancel (Anytime)**    
  **Qualifying Event\***

\*Qualifying event such as marriage or birth of a child.

**I elect Optional Dependent Term Life Insurance coverage for the following dependents:** (please print clearly)

Please write additional names on back of form.

	Social Security #/Date of Birth	Add	Drop
Name:	SSN:		
Relationship:	DOB:		
Name:	SSN:		
Relationship:	DOB:		
Name:	SSN:		
Relationship:	DOB:		
Name:	SSN:		
Relationship:	DOB:		
Name:	SSN:		
Relationship:	DOB:		

**Please return the completed form to ERSC.**

I am enrolling in optional dependent term life coverage and I authorize MCPS to deduct the bi-weekly payroll deduction from my earnings until further notice. My contributions for insurance are under a contract issued by The Prudential Insurance Company of America. 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 bi-weekly payroll deduction for coverage.

Signature Required \_\_\_\_\_ Date \_\_\_\_\_