Department of Personnel Services

Employee Benefits Office
Dave Comerchero,
Employee Benefits Manager

County of Sacramento

CRITICAL ILLNESS APPLICATION

Employee Name _____ PIN _____

Date of Birth _____ Date of Hire _____

You and any dependents enrolling in the Critical Illness Plan must be covered under a comprehensive health care plan.

Employee Coverage* ☐ Increase ☐ Decrease

Enter amount applying for in multiples of $10,000 (maximum of $100,000)	**$**

Dependent Coverage

	Description	Maximum	Minimum	Increments
Spouse*	Must be under age 65 and have 50% or less of employee amount	$50,000	$5,000	$5,000
Child	Must be under age 26 and coverage cannot exceed $15,000 or 50% of employee amount	$15,000	$2,500	$2,500

Relation	Action	Name	DOB	Amount
Spouse*	☐ Increase ☐ Decrease			$
Child	☐ Increase ☐ Decrease			$
Child	☐ Increase ☐ Decrease			$
Child	☐ Increase ☐ Decrease			$
Child	☐ Increase ☐ Decrease			$

*Must also complete Critical Illness Health Statement Questionnaire

I agree that the coverage applied for is subject to the terms of the plan and shall become effective on the date established by the plan, provided the evidence of good health is satisfactory to Prudential. Any dependents listed are my lawful spouse/domestic partner/and children. I certify that I (and any dependents which this application applies) am currently insured under a comprehensive health care plan. I authorize my employer to deduct from my wages the required premiums.

_____ _____

Employee Signature Date

Office Use Only	EOI Received? ☐ Yes ☐ No	Date sent to Prudential:
		If Approved—Effective Date