Print Form

Department of Personnel Services

Employee Benefits Office
Dave Comerchero,
Employee Benefits Manager

County of Sacramento

DATE STAMP AREA

LIFE INSURANCE COVERAGE ELECTIONS

Last Name _____ First Name _____ Personnel Number _____

Hire Date _____ Rep Unit _____ Base Annual Salary $ _____

EMPLOYEE COVERAGE

BASIC-County Paid, no cost to employee

☐ $15,000	Rep Units 005 & 008
☐ $18,000	Rep Units 001, 002, 003, 004, 006, 007, 010, 013, 014, 016, 017, 018, 019, 022, 023, 025, 026, 028, 030, 031, 033, 034, 060, 070, 080
☐ $50,000	Rep Units 020, 021, 024, 027, 029, 032, 050

OPTIONAL-Employee paid, coverage is multiple of base annual salary

☐ Option 1A-capped at $50,000 ☐ Option 1 ☐ Option 2 ☐ Option 3 ☐ Option 4 ☐ Option 5

SPOUSE/PARTNER COVERAGE

Last Name	First name	Birthdate	SSN

BASIC
☐ $2,000
☐ $5,000 (Reps 005/008 only)

OPTIONAL-Enter spouse coverage amount in multiples of $10,000
Maximum allowed for spouse is equal to employee coverage rounded down to nearest $10,000-cannot exceed $250,000

$ _____

☐ **Max Available**

CHILD COVERAGE-choose Basic and/or Optional coverage

Last Name	First name	Birthdate	SSN	Basic $2k/$5k	Optional $15,000
				☐	☐
				☐	☐
				☐	☐
				☐	☐
				☐	☐

I authorize my employer to deduct from my wages the premium, if any, for the selected coverage(s). To the best of my knowledge, the information I have provided on this form is true and correct. I understand my coverage begins on the effective date assigned, provided I am actively at work.

_____ _____

EMPLOYEE SIGNATURE **DATE**

Employer Verification	Date

Rev 10/16