

Department of Personnel Services

Employee Benefits Office
Dave Comerchero,
Employee Benefits Manager



County of Sacramento

DATE STAMP AREA

SPECIAL DISTRICT LIFE INSURANCE FORM OPEN ENROLLMENT

Last Name _____ First Name _____ SSN _____

Hire Date _____ Phone _____ Email _____

District Name _____

Base Annual Salary \$ _____

Current Coverage Basic only, no optional

Option 1A Option 1 Option 2

Option 3 Option 4 Option 5

SPOUSE/DP LIFE INSURANCE-Choose Basic and/or Optional coverage. Optional cannot exceed employee coverage

Last Name	First Name	SSN	Birthdate	Optional Amount
SP/DP				\$

CHILD LIFE INSURANCE-Choose one or both options for child life insurance

Last Name	First Name	SSN	Birthdate	Optional \$15,000
Child				<input type="checkbox"/>
Child				<input type="checkbox"/>
Child				<input type="checkbox"/>
Child				<input type="checkbox"/>
Child				<input type="checkbox"/>

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

Employee Signature

Date