Department of Administrative Services
Division of Employee Benefits

MILWAUKEE COUNTY GROUP LIFE INSURANCE

(Use to ENROLL, DECLINE, CANCEL OR CHANGE BENEFICIARY)

Name **Birth Date**

_____ _____
Last First Initial

Social Security Number: _____

☐ **DO NOT ENROLL ME** in the group life Insurance
(If waived, cannot enroll at later date.)

☐ **CANCEL** Coverage
(Cancellation is after last premium paid month)

☐ **ENROLL** Me in the group life insurance I authorize a deduction from my pension check once a month for my share of the premium

☐ **NAME CHANGE** Former Name: _____

☐ **CHANGE OF BENEFICIARY**
I hereby designate the following as beneficiary or beneficiaries

Full Name	Date of Birth	Relationship	Share (%)	Beneficiary Type Primary / Contingent
_____	___/___/_____	_____	_____	_____
_____	___/___/_____	_____	_____	_____
_____	___/___/_____	_____	_____	_____
_____	___/___/_____	_____	_____	_____
_____	___/___/_____	_____	_____	_____

I am confirming that all information is represented accurately and that dependent/s listed on my record are eligible for coverage under the terms of Milwaukee County's benefit plans. I understand I may be required to provide verification of all information contained within my enrollment record.

SIGNATURE of APPLICANT (must be in ink)	**DATE**

Courthouse Room 210 901 North 9th Street, Milwaukee, WI 53233
Phone: (414) 278-4198 Fax: (414) 223-1379