SISC
Self-Insured Schools of California
Schools Helping Schools

Voluntary Term Life Insurance Enrollment Form Underwritten by The Lincoln National Life Insurance Company

EMPLOYEE SECTION

SOCIAL SECURITY NO.	LAST NAME (PRINT)	FIRST NAME (PRINT)		GENDER: □ MALE □ FEMALE
DATE OF BIRTH (MM/DD/YYYY)	STREET ADDRESS	CITY	ZIP	TELEPHONE NO.

VOLUNTARY LIFE COVERAGE ELECTION

	Benefit Amount	Monthly Premium Amount (12/Year)
Employee	$_____	$_____
*Spouse/Dom Partner	$_____	$_____
Dependent Child(ren)	$_____	$_____

Note *If you are required to pay premiums for any coverage, the enrollment form must be signed and dated to authorize payroll deductions. The premium amounts indicated on this form are estimates, and are subject to change based on the final terms and conditions of the policy as well as your salary and age on the effective date of the policy.*

Employee: Newly hired employees (within 31 days of hire date or 31 days of being newly eligible) are Guaranteed an Issue Amount (GIA) of up to $250,000 of Voluntary Term Life Insurance (VTL). Any amounts submitted after 31 days require evidence of insurability. Spouse/Domestic Partner: GIA of 100% of the employee's benefit, up to $50,000 of VTL. Any amounts submitted after 31 days OR over the GIA require evidence of insurability. Employee must elect coverage in order for spouse and dependents to be eligible. Spouse age is based on employee age as of policy anniversary date for premium and eligibility purposes. The following eligibility guidelines apply for dependent coverage: **Your dependent child(ren) must be under age 26. If any premium is paid for child(ren) coverage after your child(ren) attain the limiting age, the premium will be refunded in accordance with the terms of the policy.

*SPOUSE/DOMESTIC PARTNER (Required for spouse/domestic partner coverage)

LAST NAME (PRINT)	FIRST NAME (PRINT)	SOCIAL SECURITY NO.	DATE OF BIRTH (MM/DD/YYYY)	RELATIONSHIP (Spouse/Domestic Partner)

STREET ADDRESS	CITY	STATE	ZIP CODE

BENEFICIARY FOR DEATH BENEFITS (Right to change beneficiary is reserved to the insured.)

Primary Beneficiary Designation

LAST NAME (PRINT)	FIRST NAME (PRINT)	RELATIONSHIP (Spouse, Son, Daughter, etc.)	DATE OF BIRTH (MM/DD/YYYY)	ADDRESS OF BENFICIARY (Address, City, State, Zip)	BENEFIT PERCENTAGE (%)
Attach a separate sheet if necessary				Percentage Total	100%

Secondary Beneficiary Designation

LAST NAME (PRINT)	FIRST NAME (PRINT)	RELATIONSHIP (Spouse, Son, Daughter, etc.)	DATE OF BIRTH (MM/DD/YYYY)	ADDRESS OF BENFICIARY (Address, City, State, Zip)	BENEFIT PERCENTAGE (%)
Attach a separate sheet if necessary				Percentage Total	100%

AGREEMENT AND SIGNATURE

FRAUD WARNING: A PERSON MAY BE COMMITTING INSURANCE FRAUD IF HE OR SHE SUBMITS AN APPLICATION CONTAINING A FALSE OR DECEPTIVE STATEMENT WITH THE INTENT TO DEFRAUD (OR KNOWING THAT HE OR SHE IS HELPING TO DEFRAUD) AN INSURANCE COMPANY. THE FALSITY OF ANY STATEMENT IN THIS APPLICATION SHALL NOT BAR THE RIGHT TO RECOVERY UNDER THE POLICY UNLESS SUCH FALSE STATEMENT WAS MADE WITH ACTUAL INTENT TO DECEIVE OR UNLESS IT MATERIALLY AFFECTED EITHER THE ACCEPTANCE OF THE RISK OR THE HAZARD ASSUMED BY THE INSURER. NOTE: CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

I represent that the information I have provided in this enrollment form is complete, true and accurate to the best of my knowledge. I understand that payment of premium does not ensure my eligibility for coverage. I understand and agree that I must satisfy all active work and/or active employment requirements that pertain to the policy to be eligible for coverage. I understand and agree that life insurance coverage for my eligible dependents may be delayed if they are confined in a hospital on the date insurance would otherwise begin in accordance with the terms of the policy. Should I decline coverage(s), I understand and accept the Waiver of Group Insurance provisions that follow. **By signing below, I acknowledge that I understand and agree to the above statements, and that I have read and understand the benefit summaries provided to me for each line of coverage.**

EMPLOYEE SIGNATURE:_____ **DATE:** ____/____/____

WAIVER OF GROUP INSURANCE

Should I apply for waived coverage(s) in the future (either for myself or my eligible dependent(s)); I understand that evidence of insurability may be required, acceptable to the Insurance Company, at my own cost.

TO BE COMPLETED BY DISTRICT (REQUIRED)

DISTRICT NAME:			DISTRICT ID #
HIRE DATE:	EFFECTIVE DATE:	HOURS WORKED/WEEK:	JOB DESCRIPTION /CLASSIFICATION (Classified/Certificated etc.)

DISTRICT SIGNATURE (Required) **DATE:**

Revised 11-25-2019