# Dependent Life Insurance

HR-BEN-064

## Section 1 - Information and Instructions

The purpose of this form is to enroll or modify employee's Dependent Life Insurance.

It is important to complete all sections of the form. If any relevant information should change, please resubmit this request form, highlighting the changes.

Please fax a signed copy of the form to 212-852-8700 or e-mail a signed copy of the form to bscservice@mtabsc.org.

If you have any questions, please contact MTA Business Service Center (BSC) at 646-376-0123 or bscservice@mtabsc.org.

## Section 2 - Agency Information

| Print Name | Last | First | M.I. | Suffix | BSC ID |
|---|---|---|---|---|---|
| Agency (check one) | ☐ BSC ☐ LI Bus | ☐ B&T ☐ LIRR | ☐ CC ☐ MNR | ☐ HQ Civilian ☐ MTA Bus | ☐ HQ Police ☐ NYCT | Department |
| Work Address | | | | | |
| City | | | State | | Zip Code |
| Phone (W) | | E-mail | | | |

## Section 3 – Enrollment or Change in Coverage

*The Metropolitan Transportation Authority provides basic Dependent Life Insurance coverage in the amount of $5,000 for your spouse and $1,000 for each dependent child at no cost to the employee. You can purchase additional dependent life insurance protection for your eligible dependents as indicated below*

☐ Option 1: Additional $5,000 spousal and $1,000/child coverage. Total coverage: $10,000 spouse; $2,000/child

☐ Option 2: Additional $10,000 spousal and $2,000/child coverage. Total coverage: $15,000 spouse; $3,000/child

☐ Option 3: Additional $15,000 spousal and $3,000/child coverage. Total coverage: $20,000 spouse; $4,000/child

☐ Option 4: Additional $20,000 spousal and $4,000/child coverage. Total coverage: $25,000 spouse; $5,000/child

☐ Check this box if you are changing or revoking your previous election.

## Section 4 – List Dependent to be Covered

| Full Name | Relationship | Social Security # | Birth Date |
|---|---|---|---|
| | | | |
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## Section 5 – Beneficiary Information

*You are automatically the beneficiary under the Dependent Life Insurance Plan, unless otherwise indicated below. (You may designate more than one person as your primary and/or contingent beneficiary. (Use a separate sheet if more space is needed)*

☐ Check this box if you are changing or revoking your previous beneficiary designation

A) Primary Beneficiary

| Full Name | Date of Birth | Social Security # | Relationship to Employee | Home Address (street, city, state, zip code) |
|---|---|---|---|---|
| | | | | |

B) Contingent Beneficiary

| Full Name | Date of Birth | Social Security # | Relationship to Employee | Home Address (street, city, state, zip code) |
|---|---|---|---|---|
| | | | | |

## Section 6 – Authorization

*I hereby request Dependent Life Insurance and authorize my employer to make deductions from my earnings of the required contributions to apply toward the premiums for the insurance provided for in the policy issued to my employer by the carrier. Further, I hereby represent and agree that all answers and statements in this request are full, complete and true to the best of my knowledge and understand that said answers and statements from the basis upon which insurance will be made effective.*

*Additionally, I understand that if at a later date, I decide I would like to increase coverage in the plan; I may be required to provide evidence of good health for each eligible dependent satisfactory to the carrier. Furthermore, I understand that my increase in coverage would not be effective until approval is received from the carrier.*

| Employee Signature | Date |
|---|---|

**For Payroll Use Only:**

Effective Date