Political Subdivision Group Life Enrollment

FOR OFFICE USE ONLY

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alaska.gov/drb

Division of Retirement and Benefits
P.O. Box 110203
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SECTION I: MEMBER INFORMATION

NEW EMPLOYEE CHANGE OF STATUS

EMPLOYER NAME

EMPLOYER # | LOCATION

EMPLOYER MAILING ADDRESS

CITY | STATE | ZIP CODE

EMPLOYEE NAME (LAST / FIRST / M.I.) | SOCIAL SECURITY NUMBER | DATE OF BIRTH ___MM___ /___DD___ /___YYYY___

EMPLOYEE MAILING ADDRESS | CITY | STATE | ZIP CODE

MALE FEMALE | MARRIED SINGLE | # OF HOURS WORKED/WEEK | DATE HIRED FULL-TIME ___MM___ /___DD___ /___YYYY___

BASIC EARNINGS (REFER TO YOUR PLAN ADMINISTRATOR FOR PROPER EARNINGS DEFINITION)

$_____ + $_____ $_____ = $_____

BASE EARNINGS | COMMISSIONS (IF APPLICABLE) | BONUS (IF APPLICABLE) | TOTAL EARNINGS

HOURLY MONTHLY SALARIED/EXEMPT
WEEKLY SEMI-MONTHLY HOURLY/NON-EXEMPT
BI-WEEKLY ANNUALLY COMMISSIONED

OCCUPATION / JOB TITLE

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DATE RECEIVED ___MM___ /___DD___ /___YYYY___

MEMBER #

OCC CODE

RECEIVED/RECORDED DATE ___MM___ /___DD___ /___YYYY___

SECTION II: EMPLOYEE COVERAGE REQUESTED

Select or refuse only the coverage(s) included in your employer's policy.

Basic Life and AD&D	$_____	REQUEST REFUSE
Select Life and AD&D	$_____	REQUEST REFUSE

SECTION III: PRIMARY BENEFICIARY DESIGNATION

	FULL LEGAL NAME OF PERSON, TRUST, OR INSTITUTION	ADDRESS, CITY, STATE, ZIP+4	RELATIONSHIP TO MEMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER (OR TIN)	% OF BENEFIT
1.						
2.						
3.						
4.						

Continued on reverse

SECTION IV: SECONDARY BENEFICIARY DESIGNATION (Will only receive benefits if all primary beneficiaries are deceased.)

	FULL LEGAL NAME OF PERSON, TRUST, OR INSTITUTION	ADDRESS, CITY, STATE, ZIP+4	RELATIONSHIP TO MEM/BER	DATE OF BIRTH	SOCIAL SECURITY NUMBER (OR TIN)	% OF BENEFIT
1.						
2.						
3.						
4.						

SECTION V: REQUEST FOR CHANGE

1.	PLEASE ADD DEPENDENTS TO MY GROUP INSURANCE COVERAGE. REASON: MARRIAGE BIRTH OF CHILD OTHER (EXPLAIN)_____	DATE I ACQUIRED ELIGIBLE DEPENDENTS ____MM____ /____DD____ /____YYYY____
2.	PLEASE CHANGE MY NAME. (INCLUDE FIRST, MIDDLE, AND LAST) FROM:_____ TO:_____	

SECTION VI: SIGNATURE

In completing this form, I acknowledge that a person who knowingly makes a false statement, or falsifies or permits to be falsified, in an attempt to defraud the system, is guilty of a class A misdemeanor, which, upon conviction, is punishable by a fine of not more than $500.00 or by imprisonment for not more than twelve months or both. AS 39.35.670; AS 11.56.210. I also acknowledge that a person who obtains funds and/or benefits by deception may be subject to prosecution for other crimes, including theft, which may be charged as misdemeanors or felonies with potential fines and penalties including imprisonment. I also acknowledge that a person who obtains funds and/or benefits from the system unlawfully may also be required to make restitution.

SIGNATURE	DATE ____MM____ /____DD____ /____YYYY____

IMPORTANT: Please complete a new form if you want to change your beneficiaries. The most recent valid beneficiary form will be used to pay any benefits.