

## INSURANCE ENROLLMENT FORM

**Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.**



Send completed form to:  
200 E. Santa Clara St., 4<sup>th</sup> Floor Tower  
San Jose, CA 95113

Offered by Life Insurance  
Company of North America

**Employer:** City of San Jose

**ALL ABOUT YOU – THE EMPLOYEE**

Your Name \_\_\_\_\_ **Social Security #** \_\_\_\_\_ **Birthdate** \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Employee ID # \_\_\_\_\_ Gender: \_\_\_\_\_

**COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE OR DOMESTIC PARTNER\***

I am currently married and my date of marriage is: \_\_\_\_\_ or  I currently have an eligible Domestic Partner

**My Spouse/  
Domestic Partner's  
Information** Name \_\_\_\_\_ **Social Security #** \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Gender \_\_\_\_\_

*\*To be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or Affidavit on file with your employer, and accepted by the Insurance company. If not, an Affidavit should be requested from your employer.*

**YOUR COVERAGE ELECTIONS**  
View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.


Employee-Paid (Voluntary) Accidental Death & Dismemberment Insurance Policy # OK0010280		
Applicant	Available Coverage	Accept your desired coverage amount or decline coverage below.
Employee	<input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$90,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$120,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$300,000, <input type="checkbox"/> \$400,000 <input type="checkbox"/> \$500,000**	<input type="checkbox"/> Decline Coverage
Family	Spouse and Children will receive a percentage of the Employee's selected coverage amount. Rates will be higher if you elect Employee & Family coverage.	<input type="checkbox"/> Accept Coverage <input type="checkbox"/> Decline Coverage

**\*\*This is the maximum amount that you can choose under this plan.**  
 All coverage elected during this enrollment period will take effect on the latest of 01/01/2026, the date your election form is received by your employer, or if applicable the day your Evidence of Insurability Form is approved by the Insurance Company.

**SIGN HERE TO ACCEPT YOUR DEDUCTION FROM YOUR PAYCHECK**

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to New York Life Group Benefit Solutions' approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

**Caution:** For your protection California law requires the following statement to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Please Sign Here  Signature \_\_\_\_\_ Date \_\_\_\_\_

**BENEFICIARY SECTION**

To specify a beneficiary, complete the section below. You will be the beneficiary for your spouse and child(ren). If you need additional space to indicate your beneficiary designations, attach a separate piece of paper using the below format including the appropriate policy number, the date, and your signature.

Voluntary Accidental Death & Dismemberment Insurance			Policy No. OK0010280	
Employee's Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
Employee's Contingent Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)

**Community Property Laws**—If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington or Wisconsin), and name someone other than your spouse as beneficiary payment of benefits may be delayed or disputed unless your spouse provides their signature in the space provided below.

Spouse Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Employee Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

© 05/2025 New York Life Insurance Company, New York, NY. All Rights Reserved. NEW YORK LIFE and the New York Life box logo are trademarks of New York Life Insurance Company.

Form #TL-009334 © 2025 New York Life Insurance Company, New York, NY. All Rights Reserved. NEW YORK LIFE and the New York Life box logo are trademarks of New York Life Insurance Company.

Created on 05/2025.