Department of Personnel Services
Employee Benefits Office

County of Sacramento

DATE STAMP AREA

2024 SPECIAL DISTRICT VOYA ENROLLMENT LIFE INSURANCE FORM

Last Name _____ **First Name** _____ **SSN:** _____

Phone_____ **Email:** _____ **District Name**_____

Check all that apply:

☐Increase Coverage	☐ Dependent Enrollment	☐Decrease Optional Coverage	☐Waive All Optional Coverage

Employee Coverage Elections:

☐**Option 1A** (1X salary Less Basic Life Cap at $50K)	☐**Option 1** (1X salary up to $600K) Includes Basic Life	☐**Option 2** (2X Salary up to $600K) Includes Basic Life	☐**Option 3** (3X Salary up to $600K) Includes Basic Life
☐**Option 4** (4X Salary up to $600K) Includes Basic Life	☐**Option 5** (5X Salary up to $600K) Includes Basic Life	☐**Option 6** (6X Salary up to $1Million) Includes Basic Life (Medical Underwriting is required)	**Option 7** (7X Salary up to $1Million) Includes Basic Life (Medical Underwriting is required)

Spouse Coverage Elections: Choose Basic and/or Optional Coverage. Optional amount from $10,000 up to $250,000 in multiples of $10,000.					**Basic**	**Optional**
SP/DP	Last Name	First Name	SSN	Birthdate	$2k/$5k	Amount
					☐	☐ $

Child Coverage Elections -Choose Basic and/or Optional coverage.					**Basic**	**Optional**
Child(ren)	Last Name	First Name	SSN	Birthdate	$2k/$5k	$15,000
					☐	☐
					☐	☐
					☐	☐
					☐	☐

I authorize my employer to deduct from my wages the premium, if any, for the elected coverage. To the best of my knowledge and belief, the information I have provided on this form is correct. I understand my coverage begins on the effective date assigned, provided I am actively at work.

Employee Signature _____ **Date** _____