



Group Term Life Insurance
Fairfax County Employees' Retirement System (FCERS)
Fairfax County Public Schools - Group Policy Number 27515-G

Check appropriate boxes

- New Enrollment**
 Term employee optional coverage
 Name changed from _____
 Add dependent coverage effective _____
 Term dependent coverage effective _____
 Change (Check reason and include date of change)
 Marriage _____
 Birth/Adoption _____
 Death _____
 Court Order _____

Please print

Name of Employee (Last/First/Middle):	Date:	Employee ID #:
Date of Birth (Month/Day/Year):	Social Security Number:	
Home Phone Number (include area code)	Email address:	

Providing your Social Security number (SSN) is optional. Failure to provide it may result in processing delays or errors, but will not result in a denial of benefits. The full text of the FCPS SSN privacy notice can be found at www.fcps.edu/DHR/applicants/disclosures.htm.

Please print and check all appropriate boxes

Change my beneficiary to: (Revoking all prior designations)

Beneficiary Name	Relationship	Date of Birth		Percentage
			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	
			<input type="checkbox"/> Primary <input type="checkbox"/> Contingent	

CHECK FOR EMPLOYEE COVERAGE:

Basic employer-paid coverage of 1 times salary.

CHECK FOR ADDITIONAL EMPLOYEE COVERAGE:

Optional employee-paid coverage of 1 times salary.
 Optional employee-paid coverage of 2 times salary.

CHECK FOR DEPENDENT COVERAGE: If coverage is elected, complete the information below.

Spouse coverage \$5,000/Child coverage \$2,000
 (child: age 10 days to 21 years, or 25 if a full-time student at an accredited post secondary school)
 Spouse coverage \$10,000/Child coverage \$5,000
 (child: age 10 days to 21 years, or 25 if a full-time student at an accredited post secondary school)

NAME	BIRTH DATE	RELATIONSHIP
		Spouse
		Child
		Child
		Child

I understand that my coverage is subject to the underwriting guidelines of the plan. Any guaranteed insurance will be effective only if this application is dated prior to the end of the enrollment period. I authorize payroll deductions to be made as required for the coverage elected above.

Either fax your forms to 571-423-5000; pony to Benefit Processing, Office of Benefit Services, Fairfax School Administration Center; or mail to Office of Benefit Services, Department of Human Resources, 8115 Gatehouse Road, Suite 2700, Falls Church, VA 22042.

Signature: _____ **Date** _____

Office Use Only:		
Effective Date: _____	Retirement Date: _____	Payroll Entered: _____
Recorded by: _____	Date: _____	