



Political Subdivision Group Life Enrollment

FOR OFFICE USE ONLY

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alaska.gov/drb

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SECTION I: MEMBER INFORMATION

<input type="checkbox"/> NEW EMPLOYEE <input type="checkbox"/> 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
<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE	
		# OF HOURS WORKED/WEEK	DATE HIRED FULL-TIME MM / DD / YYYY
BASIC EARNINGS (REFER TO YOUR PLAN ADMINISTRATOR FOR PROPER EARNINGS DEFINITION) \$ _____ + \$ _____ = \$ _____ <small>BASE EARNINGS COMMISSIONS (IF APPLICABLE) BONUS (IF APPLICABLE) TOTAL EARNINGS</small>		<input type="checkbox"/> HOURLY <input type="checkbox"/> MONTHLY <input type="checkbox"/> WEEKLY <input type="checkbox"/> SEMI-MONTHLY <input type="checkbox"/> BI-WEEKLY <input type="checkbox"/> ANNUALLY	<input type="checkbox"/> SALARIED/EXEMPT <input type="checkbox"/> HOURLY/NON-EXEMPT <input type="checkbox"/> 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	\$ _____	<input type="checkbox"/> REQUEST <input type="checkbox"/> REFUSE
Select Life and AD&D	\$ _____	<input type="checkbox"/> REQUEST <input type="checkbox"/> 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.	<input type="checkbox"/> PLEASE ADD DEPENDENTS TO MY GROUP INSURANCE COVERAGE.	DATE I ACQUIRED ELIGIBLE DEPENDENTS
	REASON: <input type="checkbox"/> MARRIAGE <input type="checkbox"/> BIRTH OF CHILD <input type="checkbox"/> OTHER (EXPLAIN) _____	____ MM ____ / ____ DD ____ / ____ YYYY ____
2.	<input type="checkbox"/> PLEASE CHANGE MY NAME. (INCLUDE FIRST, MIDDLE, AND LAST)	
	FROM: _____ TO: _____	

SECTION VI: SIGNATURE

<p>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.</p>	
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.