

# Optional Dependent Life Enrollment Form For University of San Francisco

## SECTION TO BE COMPLETED BY EMPLOYEE

Name (print)    First                      Middle                      Last	CWID (USF)No.	Date of Birth (Mo./Day/Yr.)	<input type="checkbox"/> Male <input type="checkbox"/> Female																				
Address    Street                                      City                                      State    Zip Code	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced																						
Email Address	Phone No. (include area code)																						
<p><b>Dependent Spouse/ California Registered Domestic Partner Coverage</b>                  Spouse coverage: attach a copy of your marriage certificate                  For California Registered Domestic Partner coverage, you must complete and attach a Legally Domiciled Adult Affidavit and copy of your CA Registered Domestic Partner certificate.</p> <p>Monthly Premium Coverage: \$1.40 for all coverages</p> <p>Check the applicable box: Coverage is \$5,000  <input type="checkbox"/> I elect Spouse Coverage or California Domestic Partner  <input type="checkbox"/> My California Registered Domestic Partner Affidavit is attached.</p> <p><b>Dependent Child Coverage is \$500 birth to 6 months and \$2,000 after 6 months.</b>  <input type="checkbox"/> I elect Child coverage</p> <p>Dependent Life (if available): If your spouse/CA Registered Domestic Partner and/or child(ren) are to be covered, please provide their full legal name, date of birth and social security number here. Attach additional pages if necessary.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 30%;">Coverage</th> <th style="width: 30%;">Full Legal Name (First, MI, Last)</th> <th style="width: 20%;">Social Security Number</th> <th style="width: 20%;">Date of Birth</th> </tr> </thead> <tbody> <tr> <td colspan="4">Spouse/CA Registered Domestic Partner:</td> </tr> <tr> <td colspan="4">Dependent Child:</td> </tr> <tr> <td colspan="4">Dependent Child:</td> </tr> <tr> <td colspan="4"> </td> </tr> </tbody> </table> <p>Note: Medical Evidence of Insurability will be required for any employee who applies for coverage more than 31 days past his/her eligibility date and later requests to be covered.</p>				Coverage	Full Legal Name (First, MI, Last)	Social Security Number	Date of Birth	Spouse/CA Registered Domestic Partner:				Dependent Child:				Dependent Child:							
Coverage	Full Legal Name (First, MI, Last)	Social Security Number	Date of Birth																				
Spouse/CA Registered Domestic Partner:																							
Dependent Child:																							
Dependent Child:																							

Please notify USF Office of Human Resources of any changes in the status of his/her spouse, CA Registered Domestic Partner or dependents.

### For Payroll Deduction Authorization by the Employee

I **authorize** my employer to deduct the required contributions from my pay for the supplemental coverage requested in this enrollment form. This authorization applied to such coverage until I rescind it in writing.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date Signed (Mo./Day/Yr.)