## CITY AND COUNTYOF BROOMFIELD ENROLLMENT AND CHANGE FORM LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

☐ Initial Enrollment/Designation of Beneficiary ☐ Name Change ☐ Beneficiary Change											
Social Security #:	Last Name:					First Name:				M.I.	
Date of FT/PT Hire:		Coverage Effective Date:				Date of Birth:		Gender:			
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Eligibility: All full-time employees and part-time employees who work at least 20 hours per week on a regularly scheduled basis.											
NAMING YOUR BENEFICIARY											
It is important that your beneficiary designation be clear so that there will be no question as to your meaning. When naming your beneficiary(ies), please indicate their full name, social security number, and relationship. If the beneficiary is not related either by blood or marriage insert the words, "Not related".											
I hereby revoke any Designation of Beneficiary I may previously have made under the above Plan and designate the following as my Beneficiary(ies) under the Plan.											
Primary Beneficiary Name (s):			Social Security #:			Date of Bi		th:	Relationship to Participant:		
Contingent Beneficiary Name (s):			Social Security #:			Date of Birth:		th:	Relationshi Participant:		
Participant Signature						Date					
This instrument was signed before me on//											
						Hun	Human Resources Department Signature				