Greater Georgia Life Insurance Company

FAX TO: 678-651-1036 (Preferred)

MAIL TO: GMEBS Life & Health
Enrollment Processing
PO Box 105377
Atlanta, Georgia 30348

Application for or Changes to GGL Products/Change of Name or Address

PLEASE USE BLACK INK

Requested Effective Date:

Employer Name: City of Auburn

Group Number: G80338

SubGroup:

Reason For Desired Coverage Action:

- ☒ Hire into Eligible Position
- ☐ Late Enrollment (EOI Required)
- ☐ Job Class Change
- ☐ Part-Time to Full-time
- ☐ Family Addition (Marriage, Birth, Adoption)
- ☐ Return to Eligible Position After Leave of Absence
- ☐ Address/Name Change
- ☐ Beneficiary Change _____
- ☐ Family Reduction (Divorce, Death, Military Service, Age Limit)
- ☐ Loss of Employee Eligibility-Cancel All Life Coverage
- ☐ Cancel Optional or Dependent Coverage
- ☐ Other _____

Enter Date of Event

Part-time Date of Hire

Full-time Date of Hire 07/01/25

Affirmations of Eligibility, Job Class (if applicable), Salary (if applicable):

I affirm that the employee named below meets the following eligibility requirements:
Age 17 and older and U.S. citizen or legal resident of U.S. and income reported on W-2 form and actively at work for pay 30 hours per week or actively at work as an elected or appointed member of a City's governing authority(if employer offers coverage to this class)

The employee named below is in the following job class: [Complete if coverage amount is based on job class] _____

The employee's current annual salary is : 62000 [Complete if coverage amount is a multiple of salary]

Employer Signature Matthew Redfern Digitally signed by Matthew Redfern Date: 2025.01.15 08:26:51 -05'00' Date _____

Employee

Social Security Number:

Date of Birth:

Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed

Date of End of Waiting Period :

Last Name:

First Name:

MI:

Home Address:

City:

State:

Zip Code:

Home Phone:

Sex: ☐ Male ☐ Female

COMPLETE IF DEPENDENT COVERAGE OFFERED

Spouse

Spouse Last Name: XXXXXXXXXXXXX

Spouse First Name: XXXXXXXXXXXXXX

MI:

Social Security Number: XXXXXXXXX

Date of Birth: XXXXXX

Sex: ☐ Female ☐ Male

Coverage Applied For:

☐ Add/Keep Dependent Life

☐ Waive/Cancel Dependent Life Coverage

If adding dependent, attach eligibility documentation if not already provided for Health Plan.

Please complete page 2 for additional dependents.

Employer Name: ____________________ Social Security Number: ___________

Employee Last Name: ____________ First Name: ____________ MI: __

Please complete the above information

COMPLETE IF DEPENDENT COVERAGE OFFERRED

Child

Last Name: X X X X X X X X X X X X X First Name: X X X X X X X X X X X X X X MI: __

Social Security Number: X X X X X X X X X

Date of Birth: X X / X X / X X

Sex: ☐ Female ☐ Male

Handicapped? ☐ Yes ☐ No

Coverage Applied For: ☐ Add/Keep Dependent Life ☐ Waive/Cancel Dependent Life Coverage

If adding dependent, attach eligibility documentation if not already provided for Health Plan.

Child

Last Name: X X X X X X X X X X X X X First Name: X X X X X X X X X X X X X X MI: __

Social Security Number: X X X X X X X X X

Date of Birth: X X / X X / X X

Sex: ☐ Female ☐ Male

Handicapped? ☐ Yes ☐ No

Coverage Applied For: ☐ Add/Keep Dependent Life ☐ Waive/Cancel Dependent Life Coverage

If adding dependent, attach eligibility documentation if not already provided for Health Plan.

Child

Last Name: X X X X X X X X X X X X X First Name: X X X X X X X X X X X X X X MI: __

Social Security Number: X X X X X X X X X

Date of Birth: X X / X X / X X

Sex: ☐ Female ☐ Male

Handicapped? ☐ Yes ☐ No

Coverage Applied For: ☐ Add/Keep Dependent Life ☐ Waive/Cancel Dependent Life Coverage

If adding dependent, attach eligibility documentation if not already provided for Health Plan.

Child

Last Name: X X X X X X X X X X X X X First Name: X X X X X X X X X X X X X X MI: __

Social Security Number: X X X X X X X X X

Date of Birth: X X / X X / X X

Sex: ☐ Female ☐ Male

Handicapped? ☐ Yes ☐ No

Coverage Applied For: ☐ Add/Keep Dependent Life ☐ Cancel Dependent Life Coverage

If adding dependent, attach eligibility documentation if not already provided for Health Plan.

Employer Name:

Social Security Number:

Employee Last Name

First Name:

MI:

Please complete the above information

Employee Coverage, Beneficiaries

If box is not checked, available coverage is waived or cancelled. Review carefully.

If applicable –
Annual Salary Percentage::

. X Salary

*Instructions:

* Enter amount on right or multiple of salary on left.

Check desired coverage

- ☐ Basic Life& AD&D $
- ☐ Optional (Supp.) Life/AD&D — Same amount as Basic
- ☐ STD $ per week

Primary Beneficiaries (if both alive, % selected applies)					
	Last Name	First Name	MI	Relationship	Percent
1.					
2.					
Contingent Beneficiaries (if both survive all primary ben., % selected applies)					
	Last Name	First Name	MI	Relationship	Percent
1.					
2.					

IMPORTANT: Employee may change beneficiaries at any time by completing the GGL Change of Beneficiary Form or a new version of this form. The most recent form containing a beneficiary designation will always replace any earlier beneficiary designations.

The terms of the certificate statement of benefits provided to your employer will control, and this form cannot create benefits to which you are not entitled. If you select a coverage, or a combination of coverages not available to you, your selection will be changed to match the coverage available.

Evidence of Insurability for Contributory Coverage Due to Late Enrollment:
If you are applying for coverage more than 30 days after the date of eligibility or a change in status, that is a late enrollment. If you must pay any part of the price of coverage, you must complete GGL's evidence of insurability form and send it directly to GGL for review. Contributory coverage will not be effective unless GGL approves.
Evidence of Insurability for Benefit Amounts Exceeding the Guaranteed Issue Amount:
If the amount of coverage is based on your income and exceeds the guaranteed issue amount applicable to your employer, you must complete the GGL evidence of insurability form and send it directly to GGL for review. Coverage for any excess amount will not be added until approved by GGL.

Affirmations: I affirm that I understand the information above, and that all information entered on this form is accurate to the best of my knowledge. If I have elected dependent coverage, I affirm that each dependent listed above meets the following requirements for eligibility: Resides in the U.S. or Canada; is not in the military of any country or subdivision of any country(including a state's National Guard or a state defense force or militia); AND is either my lawful spouse and younger than age 70 or my child older than 15 days and younger than 26 years. If I have not already provided them to Georgia Municipal Association for purposes of health plan enrollment, I have attached a copy of the marriage certificate, birth certificate, and/or proof of adoption that proves this /these relationship/s. I understand that if any of these requirements is no longer met in the future, the life insurance will be terminated even if premiums are paid for it. I agree to notify the employer of any loss of eligibility for these dependents.

EMPLOYEE SIGNATURE:_____ **Date:** _____

Fraud Warning for Georgia: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading , information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.