

BART

PAYROLL AUTHORIZATION FORM OPTIONAL LIFE AND DISABILITY INSURANCE

Optional Disability Insurance

I want to apply for:

_____ Basic Short-Term Disability Insurance (Part-Time ATU and Non-Represented)

_____ Optional Long-Term Disability Insurance (Full-Time employees)

*Optional Life Insurance**

I want to apply for:

_____ ONE times my annual salary in optional life insurance

_____ TWO times my annual salary in optional life insurance

_____ THREE times my annual salary in optional life insurance

You will be enrolled in Additional and/or Voluntary life plans based on your eligibility.

* AFSCME, BPMA and Non-Represented employees are eligible for a maximum of two times annual salary in optional life insurance coverage. Life insurance coverage reduces beginning at age 65.

If Principal Financial Group approves my application, I understand that it is my responsibility to pay for the coverage(s) elected above. It is my obligation to advise the Benefits Office (x6238) if the appropriate deductions are not taken from my paycheck. Coverage is not in force if deductions are not taken.

Name: _____ Employee Number: _____
(Please Print)

Signature: _____ Date: _____

This form and the Principal Statement of Health must arrive by **5:00 PM on October 10, 2008**

Send this form and the Principal Statement of Health to BART Benefits, 300 Lakeside Dr. 20th Floor, Oakland CA 94612

FAXES ARE NOT ACCEPTED

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