

City of Montgomery

Dependent Life Benefit Change Request Form

Employee Information

Print Employee Name	Date of Birth	Employee ID #

Change Request

*Changes can only be made within 30 days of a qualifying event or during Open Enrollment.
Documentation is required.*

I elect to ENROLL in the City's Dependent Life Coverage.

Coverage: \$10,000 for Spouse. \$5,000 for each eligible child under age 26.

Cost: \$1.15/pay period. (Cost varies for School Patrol employees)

I elect to CANCEL the City's Dependent Life Coverage.

Effective Date: _____

Employee Signature

Date Signed

Phone Number

E-Mail Address

Authorized Representative Signature

Date Signed



Submit signed Change Request Form to the City of Montgomery Benefits Division

Benefits Division: 103 N. Perry St., Montgomery, AL 36104 **Ph#:** 334-625-2692 **Fax#:** 334-625-4410 **E-mail:** fgamble@montgomeryal.gov