GLENDALE COMMUNITY COLLEGE DISTRICT

Supplemental Life Insurance Enrollment Form

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Name: ______________________ **Social Security #:** ______________________

Title: ______________________ **Date of Birth:** ______________________

Date of Hire: ______________________ **Effective Date:** ______________________

Salary: ______________________

Supplemental Life Insurance - Employee

You have the opportunity to increase your Basic Life Insurance coverage by enrolling in the Supplemental Life Insurance plan. You may elect increments of $10,000 not to exceed $300,000. If you elect an amount that exceeds the **guaranteed issue amount of $100,000,** you will need to provide evidence of good health that is satisfactory to Hartford Life before the excess can become effective. If you are electing coverage **more than 31 days from the date you were first eligible to do so, you must also provide Evidence of Insurability** for the full amount of coverage.

Use the rate chart and calculation line below to determine your Monthly (12) cost for this coverage.*

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70+
Rate	$0.06	$0.06	$0.09	$0.11	$0.15	$0.22	$0.37	$0.68	$0.83	$01.27	$1.96

☐ I elect to **enroll** in the Supplemental Life plan at the Monthly (12) cost below.*

$______________ ÷ $1,000 = $______________ x $______________ = $______________

Elected Benefit Amount | Rate Above | Your Monthly(12) Cost*

☐ I elect to **decline** the Supplemental Life plan.

Your cost may change on the plan anniversary if your age category changes within the benefits plan year.

Supplemental Life Insurance – Spouse

If you elect the Supplemental Life plan for yourself, you may elect Supplemental Life coverage for your Spouse. Your election may be made in increments of $5,000 to a maximum of $50,000 but may **not exceed 50% of the approved employee election.** Spouse cost is based on employee age. If you elect an amount that exceeds the **guaranteed issue amount $25,000,** you will need to provide evidence of good health that is satisfactory to Hartford Life before the excess can become effective. If you are electing coverage **more than 31 days from the date you were first eligible to do so, you must also provide Evidence of Insurability** for the full amount of coverage.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
Rate	$0.09	$0.11	$0.14	$0.17	$0.20	$0.32	$0.56	$0.92	$1.58	$2.84

☐ I elect to **enroll** my Spouse in the Supplemental Life plan at the pay period cost indicated below.

$______________ ÷ $1,000 = $______________ x $______________ = $______________

Elected Benefit Amount | Rate Above | Your Monthly (12) Cost*

☐ I elect to **decline** the Supplemental Life plan for my Spouse.

*Your cost for spouse coverage may change if your age category changes within the benefits plan year.

SPOUSE:

First Name	Last Name	Gender	Date of Marriage	Date of Birth

PLEASE SIGN AND RETURN THIS FORM TO YOUR BENEFIT ADMINISTRATOR

Supplemental Life Insurance - Child(ren)

If you elect the Supplemental Life plan for yourself, you may elect Supplemental Life coverage for your Dependent Child(ren) between the ages of 1 days and 23 years (23 years if a full-time student) in the amount of $2,000. Children from 1 day to 6 months are limited to coverage in the amount of $500.

Use the calculation line below to determine your Monthly (12) cost for this coverage.

☐ I elect to **enroll** my Dependent Child(ren) in the Supplemental Life plan at the Monthly (12) cost below.

____________	x	**$2,000**	÷ $1,000 =	____________	x	**$1.00**	= $ ____________
# of Children		Elected Benefit Amount				Rate	Your Monthly (12) Cost

☐ I elect to **decline** the Supplemental Life plan for my Dependent Child(ren).

CHILD:

First Name	Last Name	Gender	Date of Birth

Beneficiary Designation

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship, date of birth and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. Following are examples of the most common designations:

Primary:
- Mary J. Doe, Wife (not Mrs. John Doe).

Contingent:
- Joseph W. Doe, Son and Jane Doe, Daughter, in equal shares (50%).
- Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

	Full Name	Address	SSN	Relationship	D.O.B.	%
Primary						
Contingent						

The beneficiary for life insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Employee Confirmation

I have been given the opportunity to enroll in Glendale Community College District's Group Supplemental Life Insurance plan. I understand that if I did not enroll during my 31 day new hire eligibility period but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to Hartford Life and understand my request for coverage may be denied.

I authorize my employer to make the appropriate payroll deductions from my wages on a post-tax basis.

I am aware that if participation requirements are not met, this plan will not be implemented and the coverage elected will not be in force.

Signature: ______________________________ **Date:** ____________________

PLEASE SIGN AND RETURN THIS FORM TO YOUR BENEFIT ADMINISTRATOR