LIFE INSURANCE ENROLLMENT FORM

THE UNIVERSITY OF UTAH

Name		Employee ID#

Life Insurance Coverage through The Hartford

See the Benefits Department's website at www.hr.utah.edu/benefits or contact the Benefits Department at (801) 581-7447 for coverage details

Please indicate beneficiary designations on the back of this form.

Part I

Life insurance in the amount of your annual salary up to a maximum of $25,000.

Automatically provided to employees in benefit-eligible positions by the University at no cost to the employee.

Part II

Life Insurance in the amount of your annual salary up to a maximum of $25,000. Rate information is included on page 3 of this form.

Enroll [ ] Yes [ ] No

Part III

Life Insurance in the amount of $2,000 each on your spouse and each eligible dependent child.
You must enroll in Part II to enroll in Part III.

Enroll [ ] Yes [ ] No

Employee Supplemental Term Life Insurance

Minimum of $20,000 up to maximum of $500,000 (or five times your annual salary up to $750,000) in $5,000 increments.

If you enroll during your Initial Enrollment Period (first 90 days following your date of hire into a benefit-eligible position with the University), you may enroll in coverage up to $350,000 without providing evidence of insurability. If you would like additional coverage or are enrolling after your Initial Enrollment Period, you must complete the Life Insurance Personal Health Application.

Have you used tobacco in any form in the past 12 months? [ ] Yes [ ] No

Amount of Employee Supplemental Term Life Insurance Coverage:

$_____

Spouse Supplemental Term Life Insurance

Minimum $20,000 up to maximum of $250,000 in $5,000 increments (cannot exceed amount of your Supplemental Term coverage amount unless you have been denied coverage). You must be enrolled in Supplemental Term Insurance or have applied for enrollment to participate in this option.

If you enroll during your Initial Enrollment Period (first 90 days following your date of hire into a benefit-eligible position with the University), you may enroll in coverage up to $30,000 without providing evidence of insurability. If you would like additional coverage or are enrolling after your Initial Enrollment Period, you and your spouse must complete the Life Insurance Personal Health Application.

Spouse's Birthday (Month/Day/Year): _____

Has your spouse used tobacco in any form in the past 12 months? [ ] Yes [ ] No

Amount of Spouse Supplemental Term Life Insurance Coverage:

$_____

Dependent Child Supplemental Term

[ ] $5,000 [ ] $10,000

You must be enrolled in Supplemental Term Insurance or have applied for enrollment to participate in this option.

I have read and understand the insurance coverage information on this form and in the Your Benefit Plan booklet. I understand that coverage is provided pursuant to a Certificate of Insurance issued by The Hartford. I understand The University of Utah intends for this program to continue into the future; however, The University of Utah reserves the right to change, modify, terminate, or cancel this or any subsequent program. This program is insured by The Hartford. The University of Utah is not liable for claims or any other payments required to be made by The Hartford. The University's only responsibilities are the selection of the insurance carrier, the administration of the program, and the payment of the University's share of premiums described herein. If the insurance company fails to perform its obligations, the covered person's sole remedy will be to pursue his/her rights against The Hartford. I agree to the terms of the coverage elected with this form. I certify the information I have provided on all parts of this form is true and correct. I hereby authorize any payroll deductions of required premiums.

Employee Signature: _____ **Date:** _____

<Benefits Dept Use Only>	Entry Date:	Entered By:	QC Date:	QC By:

University of Utah Division of Human Resources – Benefits Department
420 Wakara Way, Suite 105 (801) 581-7447
Salt Lake City, UT 84108 Fax: (801) 585-7375

BENEFICIARY DESIGNATIONS

Please designate at least one Primary Beneficiary and one Contingent Beneficiary for each coverage you elect (the percent allocation must add up to 100 for each group)

(You are automatically the Primary Beneficiary if you enroll in Part III, Spouse Supplemental Term and/or Dependent Supplemental Term Life Insurance)

Parts I and II	Name, Address, and Social Security Number	Relationship to Employee	Percent Allocation
Primary Beneficiary(ies)			
Contingent Beneficiary(ies)			

Part III	Name, Address, and Social Security Number	Relationship to Employee	Percent Allocation
Primary Beneficiary	Employee	Spouse/Parent	100
Contingent Beneficiary(ies)			

Employee Supplemental	Name, Address, and Social Security Number	Relationship to Employee	Percent Allocation
Primary Beneficiary(ies)			
Contingent Beneficiary(ies)			

Spouse Supplemental	Name, Address, and Social Security Number	Relationship to Employee	Percent Allocation
Primary Beneficiary	Employee	Spouse	100
Contingent Beneficiary(ies)			

Dependent Supplemental	Name, Address, and Social Security Number	Relationship to Employee	Percent Allocation
Primary Beneficiary	Employee	Parent	100
Contingent Beneficiary(ies)			

I certify that these are my beneficiary designations for the life insurance I elected on the reverse side of this form.

Employee Signature: _____ **Date:** _____

You may change your beneficiary designation(s) at any time. Contact the Benefits Department or visit the Benefits Department's website at www.hr.utah.edu/benefits for forms and information.

University of Utah Group Life Insurance
Underwritten by Hartford Life and Accident Insurance Company
Monthly Premium Rates Effective July 1, 2015

Part II Basic Employee Life Insurance
$.15 per $1,000 of coverage

Part III Basic Dependent Life Insurance
$.33 per month

Dependent Child Supplemental Term Life Insurance
$.60 for coverage in the amount of $5,000
$1.20 for coverage in the amount of $10,000

Employee and/or Spouse Supplemental Term Life Insurance
Choose your desired coverage amount (in increments of $5,000 - minimum $20,000)
Monthly premium rate per $1,000 of coverage:

Age	Non-tobacco User	Tobacco User	Age	Non-tobacco User	Tobacco User
Under 30	$ 0.045	$ 0.076	62	$ 0.594	$ 1.180
30	$ 0.054	$ 0.084	63	$ 0.594	$ 1.281
31	$ 0.054	$ 0.092	64	$ 0.594	$ 1.339
32	$ 0.054	$ 0.092	65	$ 0.829	$ 1.524
33	$ 0.054	$ 0.092	66	$ 0.913	$ 1.657
34	$ 0.054	$ 0.101	67	$ 1.004	$ 1.791
35	$ 0.072	$ 0.109	68	$ 1.096	$ 1.950
36	$ 0.072	$ 0.109	69	$ 1.143	$ 2.101
37	$ 0.072	$ 0.126	70	$ 1.499	$ 2.486
38	$ 0.072	$ 0.126	71	$ 1.758	$ 2.849
39	$ 0.072	$ 0.126	72	$ 1.854	$ 3.130
40	$ 0.081	$ 0.150	73	$ 1.854	$ 3.490
41	$ 0.081	$ 0.159	74	$ 1.854	$ 3.901
42	$ 0.081	$ 0.185	75	$ 1.854	$ 4.370
43	$ 0.081	$ 0.193	76	$ 1.854	$ 4.921
44	$ 0.084	$ 0.210	77	$ 1.854	$ 5.415
45	$ 0.117	$ 0.226	78	$ 1.854	$ 5.901
46	$ 0.122	$ 0.243	79	$ 1.854	$ 6.428
47	$ 0.122	$ 0.276	80	$ 1.854	$ 7.023
48	$ 0.122	$ 0.302	81	$ 1.854	$ 7.683
49	$ 0.135	$ 0.335	82	$ 1.854	$ 8.429
50	$ 0.159	$ 0.377	83	$ 1.854	$ 9.283
51	$ 0.185	$ 0.427	84	$ 1.854	$ 10.262
52	$ 0.201	$ 0.469	85	$ 1.854	$ 11.040
53	$ 0.207	$ 0.527	86	$ 1.854	$ 11.928
54	$ 0.207	$ 0.603	87	$ 1.854	$ 12.848
55	$ 0.302	$ 0.636	88	$ 1.854	$ 13.744
56	$ 0.318	$ 0.695	89	$ 1.854	$ 14.639
57	$ 0.352	$ 0.761	90	$ 1.854	$ 15.585
58	$ 0.387	$ 0.829	91	$ 1.854	$ 16.639
59	$ 0.387	$ 0.904	92	$ 1.854	$ 17.803
60	$ 0.485	$ 0.987	93	$ 1.854	$ 19.058
61	$ 0.545	$ 1.088	94	$ 1.854	$ 20.306
			95	$ 1.854	$ 21.494

To calculate premium cost: Determine the premium rate that applies to your age and tobacco use. Divide your desired coverage amount by 1,000, then multiply that number by the premium rate. *For example, assume you are age 45, do not use tobacco, and want $150,000 of coverage. Your premium rate would be $.117 per $1,000 of desired coverage ($.117 multiplied by 150), for a total premium of $17.55 per month.*