GROUP BENEFITS

Los Rios Community College District
Benefits Enrollment Form – 12 Month Employee

THE HARTFORD

Information About You

Name:	Social Security Number / Employee ID Number:
Date of Birth:	Date of Hire:

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- **Step 1:** Please **enter and/or check** your coverage elections and details. *You may only elect – and will be covered for – levels of coverage included in your employer's contract.*
- **Step 2:** For newly eligible employees, please **sign, date and return** this form within 31 days to the Employee Benefits Department. For employees who are enrolling anytime after your initial eligibility period, please contact your Employee Benefits Department for instructions on providing evidence of good health.

Supplemental Life and AD&D Insurance

You can purchase Supplemental Life and AD&D Insurance in increments of $10,000. The maximum amount you can purchase cannot be more than the lesser of 5 times your annual Earnings or $750,000. If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of the lesser of 3 times your annual Earnings or $250,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess amount can become effective. If you were previously eligible and are now electing coverage for the first time, you will need to provide evidence of insurability that is satisfactory to The Hartford before any coverage can become effective. If you are electing to increase your current coverage, you will need to provide evidence of insurability that is satisfactory to The Hartford before any additional coverage can become effective.

Age	Under 29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
Rate	0.062	0.060	0.069	0.094	0.132	0.201	0.319	0.513	0.641	1.007	1.749	3.094

To calculate your Monthly cost please use the following formula(s):

_____ ÷ $1,000 = _____ x _____ = $_____

Life and AD&D Benefit Amount | Rate | My Monthly Cost

☐ I elect to **purchase** the total amount of $_____ of Life and AD&D coverage.
☐ I **decline** to purchase Life and AD&D coverage.
☐ I elect to **continue** my current Life and AD&D coverage.
☐ I elect to **increase** my current Life and AD&D coverage of $_____ by $_____ for a total benefit amount of $_____.

Spouse/Domestic Partner Supplemental Life and AD&D Insurance

If you purchase Supplemental Life and AD&D Insurance, you may purchase Spouse/Domestic Partner Supplemental Life and AD&D Insurance in increments of $5,000. The maximum amount you can purchase cannot be more than the lesser of $150,000 or 100% of your Employee Supplemental Life Insurance. If your Spouse or Domestic Partner is newly eligible and elects an amount that exceeds the guaranteed issue amount of $30,000, your Spouse or Domestic Partner will need to provide evidence of insurability that is satisfactory to The Hartford before the excess amount can become effective. If your Spouse or Domestic Partner was previously eligible and you are now electing Spouse/Domestic Partner coverage for the first time, your Spouse or Domestic Partner will need to provide evidence of insurability that is satisfactory to The Harford before any coverage can become effective. If you are electing to increase your Spouse or Domestic Partner's current coverage, your Spouse or Domestic Partner will need to provide evidence of insurability that is satisfactory to The Hartford before any additional coverage can become effective. Costs are based on Employee's age.

Age	Under 29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80+
Rate	0.062	0.060	0.069	0.094	0.132	0.201	0.319	0.513	0.641	1.007	1.749	3.094

To calculate your Monthly cost please use the following formula(s):

Prepare Today.
Help Protect Tomorrow.

Name: _____

Life and AD&D Benefit Amount	÷ $1,000 =		x	Rate	=	$ My Monthly Cost

☐ I elect to **purchase** the total amount of $_____ of Spouse/Domestic Partner Life and AD&D coverage.
☐ I **decline** to purchase Spouse/Domestic Partner Life and AD&D coverage.
☐ I elect to **continue** my current Spouse/Domestic Partner Life and AD&D coverage.
☐ I elect to **increase** my current Spouse/Domestic Partner Life and AD&D coverage of $_____ by $_____ for a total benefit amount of _____.

Spouse/Domestic Partner First Name	Spouse/Domestic Partner Last Name	Gender	Date of Birth	Date of Marriage or Eligible Partnership

Child(ren) Supplemental Life Insurance

If you purchase Supplemental Life and AD&D Insurance for yourself, you may purchase Child(ren) Supplemental Life Insurance for your Child(ren) between ages of Live Birth to 26 years old in the amount of $10,000. Child(ren) between the ages of Live Birth to 6 months are limited to coverage in the amount of $1,000.

I Elect Child(ren) Life in the total amount of and My Benefit Will Be:		My Monthly Cost For all my Covered Child(ren) Will Be:
☐	$10,000	$1.10
☐	To **decline**	$0.00

Child(ren) First Name	Child(ren) Last Name	Date of Birth	Gender

Name: _____

Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. **This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you, unless specifically named otherwise.** Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

	Full Name	Address	Social Security #	Relationship	Date of Birth	Percentage
Primary Beneficiary						
Contingent Beneficiary						

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

Spousal Consent For Community Property States Only: If you live in a community property state – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Disclaimer: Spousal consent does not apply to ERISA plans.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ Date: _____

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life insurance coverage described in the Benefit Highlight Sheets and offered through Los Rios Community College District.

I understand and agree that if I decline coverage now, but later decide to enroll, I will be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit is reduced at a specified age stated in the policy.

I authorize my employer to make the appropriate payroll deductions from my earnings.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer.

Signed _____ Date _____