LIFE BENEFIT PLAN

PMB 0141-1
Bureau of Human Resources
500 East Capitol Avenue
Pierre, SD 57501-5070
Phone: 605.773.3148
Fax: 605.773.6840

SOUTH DAKOTA
state employee
benefits program
learn. act. thrive.

(BHR USE ONLY) Remarks: _____

Employee #: _____ **Date of Hire:** ____/____/_____

HR Initials: _____ **Agency:** _____

*****Follow the instructions as listed on the second page of this form.*****

1) Name of Employee: _____
Last First Middle

2) Address: _____
Street City State Zip Code

3) SSN or Insurance ID#: _____-_____-_____ **4) Date of Birth:** _____/_____/_____
Month Day Year

5) Phone Number: (_____) _____ - _____

6) Basic Employer Paid Life Benefit Plan
A Basic coverage of $25,000 is provided to you by the State of South Dakota.

7) Optional Supplemental Life Coverage (Employee Paid)
You must check ONE of the following. For your protection, scratch outs and white outs are not accepted.

- ❑ Two Times Annual Salary
- ❑ Three Times Annual Salary
- ❑ Four Times Annual Salary
- ❑ Five Times Annual Salary
- ❑ I ELECT NOT TO PARTICIPATE IN SUPPLEMENTAL LIFE COVERAGE

8) Accidental Death & Dismemberment (AD&D) Coverage (Employee Paid)
You must check ONE of the following. For your protection, scratch outs and white outs are not accepted.

❑ Yes, I want AD&D ❑ No, I do not want AD&D ❑ Does Not Apply

9) Optional Dependent Life and AD&D Coverage (Employee Paid)
You must check ONE of the following. For your protection, scratch outs and white outs are not accepted.

❑ $10,000 ❑ I ELECT NOT TO PARTICIPATE IN DEPENDENT LIFE COVERAGE

10) Designation of Beneficiary(ies)

Designation of Primary Beneficiary(ies)

Name	Address	Relationship	Share to Each

Designation of Contingent Beneficiary(ies)

Name	Address	Relationship	Share to Each

_____ _____
Signature of Employee **Date**

INSTRUCTIONS

1) NAME

2) ADDRESS

3) SOCIAL SECURITY NUMBER OR INSURANCE ID

4) BIRTH DATE

5) PHONE NUMBER

6) BASIC EMPLOYER PAID LIFE BENEFIT PLAN

7) SUPPLEMENTAL LIFE COVERAGE: You may purchase additional term life coverage in increments of your base annual salary. The maximum supplemental coverage allowed is $400,000. When you enroll later than 30 days from the date you begin work, you will be required to provide evidence of insurability.

8) ACCIDENTAL DEATH & DISABILITY: AD&D must equal the Supplemental Life Coverage. If you participate in Supplemental Life and AD&D Coverage you may purchase dependent coverage. If elected, AD&D will apply to dependent life coverage as well, if applicable.

9) DEPENDENT LIFE COVERAGE: If you have Employee Supplemental Life, you may purchase $10,000 of Dependent Life Coverage and $10,000 of Dependent AD&D. The coverage and contribution rate applies to all eligible dependents. If elected, AD&D will apply to dependent life coverage as well, if applicable.

10) Designation of Beneficiary (ies): If you do not designate a beneficiary (ies) for your Basic or Supplemental Life Coverage, the proceeds will be paid in the following order of proceeds: Spouse, Child (ren), Parents, Estate. If you have already designated a beneficiary for your basic and supplemental life coverage you are not required to update your beneficiary again. Your primary beneficiary (ies) will receive the life and AD&D (if applicable) benefit plan proceeds. If designated, Contingent Beneficiary (is) will receive the benefit proceeds, if the primary beneficiary (is) is deceased. Employees are the beneficiary for their eligible Dependent coverage. If you have special instructions regarding beneficiary (is), or would like to designate more than the space provides, attach an additional page and indicate “Attachment” on this form.

Coverage effective dates are determined by the pay period in which the employer and employee deductions are withheld.

FOR YOUR PROTECTION, SCRATCH OUTS AND WHITE OUTS ARE NOT ACCEPTED.

YOU SHOULD RETAIN A COPY OF THIS FORM AND KEEP IT WITH YOUR IMPORTANT RECORDS. REFER TO YOUR SUMMARY PLAN DESCRIPTION DOCUMENT FOR DETAILS.

Please return this form to the Bureau of Human Resources at:

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