Trumbull Board of Education

AnthemLife

Group No. 800663E

Voluntary Group Term Life & Voluntary LTD Enrollment Form

EMPLOYEE INFORMATION. Please verify the information below for accuracy. If incorrect, please contact your HR representative.

Name/Address	Date of Birth	Employee SSN
	Employee No.	Date of Hire
	Class	Annual Salary
	Effective Date	Gender

PLEASE PRINT IN BLACK OR BLUE INK. Read and complete all of this form. If you need more space, attach a separate sheet of paper. Please use four digits for years (e.g. 1998, not 98).

Are you actively at work? Yes ☐ No ☐

Are you retired? Yes ☐ No ☐

Marital status: Single ☐ Married ☐ Widowed ☐ Divorced ☐

Occupation: _____

Phone: _____ **Fax:** _____

Hours per week working for this employer: _____ **Email Address:** _____

BENEFIT SELECTION. Check the boxes that apply along with the appropriate coverage level.

Optional Life and AD&D

Optional Life allows you to expand and enhance your benefits through convenient payroll deduction. Optional life gives you the opportunity to purchase life insurance coverage for yourself at a fraction of what insurance would cost in the individual market place. Amounts elected over $250,000 will require an evidence of insurability form to be completed.

You may elect $10,000 increments to a maximum of $500,000 or 5x salary, whichever is less. Please select a benefit amount from below or select one from the attached rate matrix.

Accept ☐ **Decline** ☐

Original Effective Date of Optional Life : _____

	Guaranteed Issue						Other Benefit
Coverage Amount	☐ $250,000.00	☐ $150,000.00	☐ $350,000.00	☐ _____
Weekly Premium	_____	_____	_____	_____

Reduction Schedule : 35% at age 65; 50% at age 70. Benefit terminates at retirement.

Optional Spouse/Domestic Partner Dependent Life

You may elect increments of $5,000 to a maximum of $100,000 not to exceed 50% of the employee benefit amount. You must elect Optional employee life in order to purchase the dependent coverage. Spouse/Domestic Partner amounts elected over $50,000 will require an evidence of insurability form to be completed.

You may elect $5,000 increments to a maximum of $100,000. Please select a benefit amount from below or select one from the attached rate matrix.

Accept ☐ **Decline** ☐

Original Effective Date of Optional Life : _____

	Guaranteed Issue			Other Benefit
Coverage Amount	☐ $50,000.00	☐ $75,000.00	☐ $100,000.00	☐ _____
Weekly Premium	_____	_____	_____	_____

Reduction Schedule : 35% at age 65; 50% at age 70. Benefit terminates at retirement.

Optional Child(ren) Dependent Life

You may elect increments of $5,000 to a maximum of $10,000 not to exceed 50% of the employee benefit amount. You must elect Optional employee life in order to purchase the dependent coverage.

You may elect $5,000 increments to a maximum of $10,000. Please select a benefit amount from below or select one from the attached rate matrix.

Accept ☐ **Decline** ☐

Original Effective Date of Optional Life : _____

	Guaranteed Issue	
Coverage Amount	☐ $10,000.00	☐ $5,000.00
Weekly Premium	$0.48	$0.24

Voluntary LTD

Voluntary LTD allows you to purchase coverage to protect your income should you become disabled after a 180 day waiting period. You can choose to protect up to 60% of your monthly earnings up to a maximum of $5,000. Your ability to earn income is your greatest asset and Long Term Disability allows you to protect your income.

Accept ☐ **Decline** ☐

Monthly Benefit Amount	Weekly Premium
_____	_____

BENEFICIARY DESIGNATION

It is important that your beneficiary designation is clear. It is also important that you name a primary beneficiary and contingent beneficiary. If the beneficiary is not related to you by either blood or marriage, please insert the words 'Not Related' in the relationship box.

BENEFICIARY DESIGNATION			In equal shares unless otherwise provided below			
Primary Beneficiary	Last name	First name, M.I.	Social Security # – –	Relationship to Applicant	Age	%
Primary Beneficiary	Last name	First name, M.I.	Social Security # – –	Relationship to Applicant	Age	%
			In equal shares unless otherwise provided below			
Contingent Beneficiary	Last name	First name, M.I.	Social Security # – –	Relationship to Applicant	Age	%
Contingent Beneficiary	Last name	First name, M.I.	Social Security # – –	Relationship to Applicant	Age	%

ELIGIBILITY AND AUTHORIZATION

Employee Confirmation

My signature certifies that I (1) Apply for the coverages designated for which I am eligible under my employer's plan with the carrier. (2) Understand if coverages have been refused, I am not entitled to benefits under those coverages and that if I want to apply later, I must furnish at my own expense proof of good health to the carrier. (3) Authorize any required deductions from my earnings. (4) Designate the beneficiary named on this application to receive any benefits payable in the event of death. (5) Represent that all of the information on this application is complete, correct and true to the best of my knowledge and belief. (6) Understand that I must be actively at work the number of hours specified in the policy/participation agreement to remain insured.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Employee Signature _____ Date _____/_____/_____

Premium calculations above may differ slightly based on rounding rules and other system factors, but will not vary significantly. Every effort has been made to match your premiums to the penny.

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.