GROUP BENEFITS

Le Moyne College - All Full-time Active Employees Benefits Enrollment Form

Information About You

Name: 29794-0	**Social Security Number / Employee ID Number:**
Date of Birth:	**Date of Hire:**
Salary:	**Location/Department/Division:**

Instructions

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

- **Step 1:** Please **enter 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:** Please **sign, date and return** this form to Human Resources.

Employer Paid Long Term Disability Insurance

Employer Paid Long Term Disability Insurance helps replace your income if you are sick or injured and cannot work and is designed to begin after you have been disabled for a predetermined waiting period, known as an elimination period, of 180 days. The coverage provided by Le Moyne College - All Full-time Active Employees provides you with income protection to replace up to 60% of your Salary to a maximum monthly benefit of $10,000 at no cost to you.

Basic Life and AD&D Insurance

Le Moyne College - All Full-time Active Employees provides, at no cost to you, Basic Life and AD&D Insurance in an amount equal to 2.5 times your annual Salary, to a maximum of $350,000

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 5 times your annual Salary or $500,000. 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 The Hartford before the excess can become effective. You may elect Life Insurance without electing AD&D, but you cannot elect AD&D without Life Insurance. The amount of AD&D must equal your approved Life Insurance election.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.0275	0.0315	0.0390	0.0545	0.0750	0.1195	0.1835	0.2995	0.4785	0.8405	1.5165	3.0710

To calculate your Semi-monthly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x _____ = $_____
Life Benefit Amount — Rate — My Semi-monthly Cost

☐ I elect to **purchase** $_____ of Life coverage.
☐ I **decline** to purchase Life coverage.

_____ ÷ $1,000 = _____ x $0.0115 = $_____
AD&D Benefit Amount — Rate — My Semi-monthly Cost

☐ I elect to **purchase** $_____ of AD&D coverage.
☐ I **decline** to purchase AD&D coverage.

Spouse Supplemental Life and AD&D Insurance

If you purchase Supplemental Life and AD&D Insurance, you can purchase Spouse Supplemental Life and AD&D Insurance in increments of $5,000. The maximum amount you can purchase cannot be more than the lesser of $100,000 or 50% of your Employee Voluntary/Supplemental Life Insurance coverage. If you elect an amount that exceeds the guaranteed issue amount of $25,000, your Spouse

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Name:_____

will need to provide evidence of good health that is satisfactory to The Hartford before the excess can become effective. You may elect Life Insurance without electing AD&D, but you cannot elect AD&D without Life Insurance. The amount of AD&D must equal your approved Life Insurance election.

Costs are based on your Spouse's's age.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.0625	0.0520	0.0570	0.0785	0.1130	0.1765	0.2750	0.4220	0.7215	1.2300	2.1965	4.3960

To calculate your Semi-monthly cost, please use the following formula(s):

_____ ÷ $1,000 = _____ x _____ = $_____
Life Benefit Amount — Rate — My Semi-monthly Cost

☐ I elect to **purchase** $_____of Life coverage.
☐ I **decline** to purchase Life coverage.

_____ ÷ $1,000 = _____ x $0.0115 = $_____
AD&D Benefit Amount — Rate — My Semi-monthly Cost

☐ I elect to **purchase** $_____of AD&D coverage.
☐ I **decline** to purchase AD&D coverage.

First Name	Last Name	Gender	Date of Birth	Date of Marriage

Child(ren) Supplemental Life and AD&D Insurance

If you purchase Supplemental Life and AD&D Insurance, you can purchase Child(ren) Supplemental Life and AD&D Insurance for your Dependent Child(ren) between the ages of Live Birth and 19 years (26 years if a full time student), in the amount(s) of $10,000. Child(ren) between the ages of Live Birth and 6 months are limited to coverage in the amount of $1,000. You may elect Life Insurance without electing AD&D, but you cannot elect AD&D without Life Insurance. The amount of AD&D must equal your approved Life Insurance election.

☐ I elect to **purchase** $10,000 of Life coverage at a Semi-monthly cost of $1.88 (cost is for all covered Children).
☐ I **decline** to purchase Life coverage.

_____ ÷ $1,000 = _____ x $0.0115 = $_____
AD&D Benefit Amount — Rate — My Semi-monthly Cost

☐ I elect to **purchase** $_____of AD&D coverage.
☐ I **decline** to purchase AD&D coverage.

First Name	Last Name	Date of Birth	Gender

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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 Le Moyne College - All Full-time Active Employees.

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. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

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 _____

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