Town of Rockland – School Employees

01-017340-00

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: Please sign, date, and return this form to your HR Department.

Information About You

Name:	Date of Birth:	Date of Hire:
Annual Salary:		

Supplemental Life & AD&D Insurance

You may purchase Supplemental Life and AD&D Insurance in increments of $5,000 in any amount from a minimum of $5,000 not to exceed the lesser of 5 x Annual Earnings or $100,000. Evidence of Insurability is required for those enrolling outside of 31 days after their initial eligibility date.

Age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	$0.730	$0.730	$0.730	$0.730	$0.730	$0.730	$0.730	$0.730	$0.730	$0.730	$0.730	$0.730

Please use the calculations below to find your total cost of desired coverage up to your maximum election based on the design of your plan.

$\_\_\_\_\_$ (Life & ADD Benefit Amount) ÷ 1,000 = $0.73 x $ _____ (Rate) = $_____ (Monthly Cost) x 12 ÷ 26 = $ _____ (My Bi-Weekly Cost)

☐ I elect to purchase the total amount of $_____ of Supplemental Life & AD&D Insurance

☐ I elect to decline Supplemental Life & AD&D Insurance

Supplemental Spouse and Child(ren) Life Insurance

If you purchase Supplemental Life Insurance, you may also purchase Supplemental Spouse Life Insurance for a flat benefit amount of $5,000.

Spouse	First Name	Last Name	Gender - Male - Female	Date of Marriage / /	Date of Birth / /

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If you purchase Supplemental Life Insurance you may also purchase Supplemental Child(ren) Life Insurance for all your child(ren) ages 15 days to age to age 25 listed below for a flat $2,000 benefit amount.

First Name	Last Name	Date of Birth	Age

☑ your election below.

I elect Life and the total amount of my benefit will be	Total bi-weekly cost will be
☐ Child $2,000	-
☐ Spouse $5,000	-
Total bi-weekly cost	$1.85
☐ **To Decline - $0**	-

Voluntary Long Term Disability Insurance — Class 1

You have the opportunity to enroll in Voluntary Long Term Disability Insurance. Voluntary Long Term Disability Insurance helps to 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 the elimination period, of 90 Days. This plan provides you with income protection to replace up to of your Salary, to a maximum monthly benefit of $5,000. If you decline coverage and seek to elect coverage at a future date, evidence of insurability will be required.

Age	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	$0.510	$0.510	$0.510	$0.510	$0.510	$0.510	$0.510	$0.510	$0.510	$0.510	$0.510	$0.510

Please use the calculations below to find your total cost of desired coverage up to your maximum election based on the design of your plan.

$_____ ÷ 12 = $_____ ÷ 100 = $_____ x $0.510 $_____ x 12 ÷ 26 = $_____

Annual Salary | Max: $100.00 | Rate | Monthly Cost | My Bi-Weekly Cost

☐ I elect to **Purchase** Voluntary Long Term Disability Insurance

☐ I **Decline** to purchase Voluntary Long Term Disability Insurance

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 only group Supplemental Life or accidental death insurance coverage issued by Symetra Life Insurance Company 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.

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

	Full Name	Address	Social Security #	Date of Birth	Relationship	% of Benefit
☐ Primary						
☐ Primary ☐ Contingent						
☐ Primary ☐ Contingent						
☐ Primary ☐ Contingent						

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.

Confirmation

I, the undersigned, an Employee of the above-named policyholder, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of the insurance **(Not applicable if the Employer pays 100% of the required contribution).**

I hereby waive my right at this time to elect the insurance coverages which I did not select above. I understand that if I do not enroll within 31 days, when first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death.

All information submitted by me on this form to the best of my knowledge and belief is true and complete.

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 any 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.

Signature: _____ Date: _____

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