GROUP #: 3242

CORTLAND COUNTY COMMUNITY ACTION PROGRAM, INC.

BASIC LIFE/ADD, DEPENDENT LIFE & SUPPLEMENTAL LIFE INSURANCE ENROLLMENT FORM

Name:		**Annual Earnings:**
Social Security #:		**Date of Hire:**
Date of Birth:	**Gender:**	**Effective Date:**

Basic Life/ADD Insurance - Employee

Your employer provides basic Life/ADD coverage in the amount of $30,000.

Dependent Life

Your employer provides Dependent Life coverage in the amount of $10,000 spouse/$4,000 child.

☐ **Eligible** for Dependent Life ☐ **Not eligible** for Dependent Life

Note: The following cost should be based on your age and your spouse's age as of January 1st.

Supplemental Life Insurance – Employee

You have the opportunity to elect Supplemental Life Insurance coverage. Your election may be made in increments of $10,000 to a maximum of the lesser of three (3) times earnings or $100,000. **The guaranteed issue amount is $100,000.**

Age	Under 34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	$0.08	$0.11	$0.19	$0.29	$0.56	$0.92	$1.20	$2.13	$2.45	$2.22

☐ I **elect** Supplemental Life coverage:

_____ ÷ $1,000 = _____ x _____ = $_____
Amount elected Rate above Monthly cost

☐ I **decline** Supplemental Life coverage.

Benefit reductions begin at age 65, see your benefits administrator for further information.

Supplemental Life Insurance – Spouse

If you elect Supplemental Life coverage for yourself, you may elect Supplemental Life coverage for your Spouse. Your election may be made in increments of $5,000 to a maximum of $50,000, but may not exceed 50% of your approved election. **The guaranteed issue amount is $50,000.**

NOTE: Spouse cost is based on the employee's date of birth.

Age	Under 34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	$0.08	$0.11	$0.19	$0.29	$0.56	$0.92	$1.20	$2.13	$2.45	$2.22

☐ I **elect** Supplemental Life coverage for my spouse.

_____ ÷ $1,000 = _____ x _____ = $_____
Amount elected Rate above Monthly cost

Spouse Name: _____

☐ I **decline** Supplemental Life coverage for my Spouse.

Supplemental Life Insurance – Child(ren)

If you elect Supplemental Life plan for yourself, you may elect Supplemental Life coverage for your Dependent Child(ren) unmarried to age 26. You may elect $5,000 per child unit.

☐ I **elect** Supplemental Life coverage for my dependent child(ren).

☐ $5,000 @ a monthly cost of $0.60

Write the name(s) and date(s) of birth of your dependent child(ren):

_____

☐ I **decline** Supplemental Life coverage for my dependent child(ren).

Beneficiary Designation

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, relationship and, if a minor, the age of that minor. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related." If you need assistance, contact Human Resources or your own legal counsel. Following are examples of the most common designations:

- Mary J. Doe, Wife (not Mrs. John Doe).
- Mary J. Doe, Wife, if living, otherwise to Joseph W. Doe, Son.
- Mary J. Doe, Wife, if living, otherwise to Jane Doe, Daughter, and Joseph W. Doe, Son, in equal shares or to the survivor.
- Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "1/3 to Mary Jones, Mother, and 2/3 to Edith Jones, Wife."

	Full Name	Address	Relationship	D.O.B.
Primary				
Contingent				

A beneficiary for employee's Life Insurance may be changed upon written request.

Employee Confirmation

I have been given the opportunity to enroll in Cortland County Community Action Program, Inc.'s group Supplemental Life coverage. I understand that if I decline now, but later decide to enroll, I will be required to provide evidence of good health that is satisfactory to the insurance carrier and understand my request for coverage may be denied.

I authorize my employer to make the appropriate payroll deductions from my wages. I am not now disabled and I am performing all the duties of my occupation on a full-time basis.

Signature: _____ **Date:** _____