



2022-2023 Enrollment Form / Change Form



Please complete this application in FULL or it will be returned, resulting in a delay in processing. You are solely responsible for its accuracy and completeness. Enrollment must occur within 30 days from the date that you or your dependent(s) become eligible.

Purpose - Dates Required

Check All That Apply

Form section for Purpose - Dates Required, including checkboxes for New Hire, Name Change, Termination, etc.

Qualifying Event - Dates Required (enrollment must occur within 30 days of event and provide proper documentation)

Form section for Qualifying Event - Dates Required, including checkboxes for Add Dependent, Termination, etc.

\*For verification purposes, employees must provide supporting eligibility documentation for Plan Administrator to process your benefits change request.

Employer's Responsibility:

Form section for Employer's Responsibility, including Date of Hire, Effective Date, Salary, etc.

Employee Information

Form section for Employee Information, including Social Security Number, Date of Birth, Marital Status, etc.

Dependent Information

Your eligible dependents include: (a) your legal spouse; (b) Your dependent children who are under age 26; (c) your legally adopted children, if they depend on you for most of their support and maintenance; (d) your step children.

Table for Dependent Information with columns: Names of Covered Family Members, Domestic Partner, Gender, DOB, SSN, Add/Remove.

Please indicate your enrollment elections by checking the appropriate Boxes

Dental (per pay period)

Form section for Dental enrollment elections, including Lincoln Financial Group, Dental Plan 1 - PPO, Dental Plan 2 - DHMO, etc.

Vision (per pay period)

Form section for Vision enrollment elections, including VSP, Base Plan, Buy Up Plan, etc.

**Basic Term Life and AD&D (Employer Paid)**

Lincoln Financial Group

Policy # 000010255658

Benefit Amount **\$25,000**

**Life Insurance Beneficiary Designation - ALL EMPLOYEES MUST COMPLETE THIS SECTION**

**Primary Beneficiary Designation**

Provide below the person(s) who should receive proceeds in the event of your death.

You may specify as many individuals as you like, but the total percent share of proceeds must equal 100%.

Please Note: If no beneficiary is designated, assets will be payable to the Estate of the insured.

Full Name	DOB	Relationship	SSN	% of Assets

**Contingent Beneficiary Designation (optional)**

Provide below the person(s) who should receive proceeds ONLY if all your Primary Beneficiary(ies) listed above are not living at the time of your death.

If listing multiple persons, the total proceeds must equal 100%.

Full Name	DOB	Relationship	SSN	% of Assets

**Voluntary Term Life and AD&D (per pay period)**

Lincoln Financial Group

Policy # 000400255660

**YOU MUST ELECT COVERAGE FOR YOURSELF IN ORDER TO COVER YOUR DEPENDENTS**

**Employee Life and AD&D Options:** (AD&D election will mirror Life election) **Increments of \$10,000 (up to 5x annual salary maximum \$300,000)**

\$10,000     \$40,000     \$70,000     \$100,000  
 \$20,000     \$50,000     \$80,000     **150,000\*** (anything over \$150,000 will require additional medical information)  
 \$30,000     \$60,000     \$90,000     Other Amount \$ \_\_\_\_\_

Waive **Life and AD&D Rates: (per \$1,000 of benefit) Maximum of \$300,000; Not to exceed 5X annual salary**

18-29	\$0.065	40-44	\$0.165	55-59	\$0.635	70-74	\$2.525
30-34	\$0.075	45-49	\$0.235	60-64	\$0.655	75-79	\$7.535
35-39	\$0.105	50-54	\$0.415	65-69	\$1.195	80+	\$16.255

**Spouse Life and AD&D Options:** (AD&D election will mirror Life election) **Increments of \$5,000 (up to 50% of the employee life amount maximum \$150,000)**

\$5,000     \$20,000     \$35,000     \$50,000  
 \$10,000     \$25,000     \$40,000     \$55,000 (anything over \$30,000 will require additional medical information)  
 \$15,000     **\$30,000 \***     \$45,000     Other Amount \$ \_\_\_\_\_

Waive **Life and AD&D Rates \*: (per \$1,000 of benefit) Maximum of \$150,000; Not to exceed 2.5 times the employee's salary**

18-29	\$0.065	40-44	\$0.165	55-59	\$0.635	70-74	\$2.525
30-34	\$0.075	45-49	\$0.235	60-64	\$0.655	75-79	\$7.535
35-39	\$0.105	50-54	\$0.415	65-69	\$1.195	80+	\$16.255

\*Spouse rates are based on the employees age

**Child Life Options: Increments of \$10,000**

\$10,000 **Life Rates: (per \$10,000 of benefit)**

Life	\$2.00
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Waive

The voluntary life coverage includes Guarantee Issue coverage in the amount of \$150,000 for Employee, \$30,000 for Spouse and \$10,000 for Child(ren). This applies to all eligible employees enrolling in the Voluntary Term Life/AD&D plan during their new hire eligibility period. If coverage is not applied for during the new hire eligibility period and coverage is requested at a later date, the full amount of coverage being applied for will be subject to medical underwriting and an Evidence of Insurability (EOI) form will be required. Please contact Human Resources to obtain the EOI form

**Supplemental Plans**

Colonial

Policy # E5335923 / C7985187

**Colonial Life Supplemental Insurance Plans - See benefit guide for plan options.**  
**If interested, complete the Colonial Interest Form and a Benefit Counselor will contact you.**  
**All elections and/or plan changes must be administered by a Benefit Counselor.**

**Acknowledgement and Signature**

**Fraud Warning: Any person who, with intent to defraud by knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.**

I verify that the information provided in this enrollment form is accurate and complete. I understand that if I have declined Voluntary Life and request to purchase such insurance at a later date: (1) I will be required to furnish evidence of insurability at my own expense; and (2) the insurance carrier will have the right to refuse my request.

I desire to participate in the coverages selected above and hereby authorize my Employer to make the necessary deduction(s) from my wage/salary to pay my portion of the premium. I understand that the plans are covered under the Cafeteria Plan (Section 125), and I will not be able to change my election during the Plan Year except during the annual Open Enrollment period, or if I experience a significant change in family status (called a "Life Event") such as, gaining or losing dependents through Birth, Death, Marriage, Divorce, or gaining or losing other health coverage, etc. I understand that I must make any changes within 30 days of the approved "Life Event." I understand that by not applying for the coverages contained herein, I will not be entitled to those benefits. I further understand that by applying for coverage at a future date, I may be asked to provide health status information for approval. Penalties such as deferred effective dates or pre-existing condition limitations may be imposed. Additionally, I agree, for myself and for any eligible dependent listed, to abide by the rules and regulations of the plan, terms and conditions of all the Service Agreements for the Plans I have elected.

Signature \_\_\_\_\_

Print Name \_\_\_\_\_

Date \_\_\_\_\_

Authorized Company Signature \_\_\_\_\_

I verify that the termination information provided is accurate and complete.