

LEWISTON PORTER UNITED TEACHERS BENEFIT FUND

Group Life and Accidental Death & Dismemberment Enrollment Form
Policy # 118668-021

Member Name: _____	Job Title: _____
Social Security Number: _____ - _____ - _____	CSEA Member: Yes No (please circle one)
Hours Worked Per Week: _____	Date of Birth: / /
Date of Hire: _____	Gender: _____

IMPORTANT! This form must be returned to the Policyholder prior to the end of the enrollment period.

Annual Enrollment Period: Elections made during this annual period are effective on the next July 1 or the date your Evidence of Insurability is approved, whichever is later. If your enrollment form is not signed, dated and returned before July 1, your prior election will remain unchanged.

New Hire Enrollment Period: When you are first eligible, you may elect any Additional coverage option. If your form is not signed, dated and returned within 31 days following your date of hire, you will automatically be enrolled only in the policyholder-funded Base plan.

Base Life and Accidental Death & Dismemberment (Paid by the Benefit Fund)

\$10,000 Life	\$10,000 AD&D
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Additional Life and Accidental Death & Dismemberment (Paid by you through payroll deduction)

Additional Life coverage amounts that are contributory and/or medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. See your Plan Administrator or refer to your member booklet for details about coverage limitations and exclusions.

Note: An Evidence of Insurability must be completed if:

- you have previously declined Additional coverage and now want to elect Additional coverage.
- you are increasing your current coverage election by more than 1 level.

Please circle the Option you are electing, complete the calculation formula below and enter your cost in the space provided.

Additional Member Life/Accidental Death & Dismemberment:

Additional Life and Ad&d Options		<u>Monthly</u>	<u>Yearly</u>
Option A	\$10,000	\$1.33	\$15.96
Option B	\$20,000	\$2.66	\$31.92
Option C	\$30,000	\$3.99	\$47.88
Option D	\$40,000	\$5.32	\$63.84
Option E	I do not wish to elect this coverage		

Additional Life/Ad&d Calculation:

$$\begin{array}{ccccccc}
 \$ \text{ } & / \$1,000 \times & \$1.33 & = \$ & \times 12 = & / & = \\
 \text{Chosen Benefit} & & \text{Rate} & & \text{Your Monthly} & & \text{Annual} \\
 \text{Amount} & & & & \text{Cost} & & \text{Premium} \\
 & & & & & & \text{\# of Annual} \\
 & & & & & & \text{Pay Periods} \\
 & & & & & & \text{Your} \\
 & & & & & & \text{Per Paycheck} \\
 & & & & & & \text{Deduction*}
 \end{array}$$

* Final cost may vary slightly due to rounding.

Beneficiary Information: Designate your beneficiary(ies) below.

Name of beneficiary (last name, first, middle initial	Relation to You	Benefit Percent
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If the beneficiary(ies) named above are not living,
then pay:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Delayed Effective Date: Initial insurance, and any increased or additional insurance will be delayed if an member is not in active employment because of an injury, sickness, leave of absence or temporary lay-off on the date that insurance would otherwise be effective.

Request for Signature: I understand that by signing and submitting this form to elect coverage, I am making a binding election for my benefits and am authorizing payroll deduction from my earnings. I understand that if I decline the additional coverages, I must wait until the next Annual Enrollment Period to make an election, unless I experience a change in status.

Member Signature

Date

