ARCHDIOCESE OF NEW YORK

VOLUNTARY SUPPLEMENTAL TERM LIFE INSURANCE ENROLLMENT FORM

Group Plan Number: GL-674263

THE HARTFORD

Employee Information

Last Name: _____ **First Name:** _____ **MI:** ____ **SSN:** _____

Date of Birth: _____ **Gender:** ❑ **Male** ❑ **Female** **Home Address:** _____ **Apt. #:** _____

City: _____ **State:** _____ **Zip:** _____ **Home Phone:** _____ **Cell Phone:** _____

Email Address: _____ **Marital Status:** ❑ **Single** ❑ **Married - Marriage Date**_____ ❑**Divorced** ❑ **Widowed**

Date of Hire: _____ **Annual Salary (As Defined by the Policy): $**_____

Enrollment Information – Please check one and list effective date

❑ Initial Enrollment	❑ Change to Existing Enrollment	❑ Beneficiary Change	Effective Date of Coverage or Change (mm/dd/yyyy): _____

Applicable Benefit Elections – Please indicate a "Coverage Amount" or "Decline Coverage" for each section:

Employee Supplemental Life Coverage (Employee Monthly Rate Table listed below)

❑ **Coverage Amount $**_____ (List any amount between $10,000 to $500,000 (increments of $10,000), not to exceed 5 times your annual salary) ❑ **Decline Coverage**

Coverage amounts over the Guarantee Issue Amount ($150,000) will require an Evidence of Insurability Health Statement, available at www.archny.org/benefits

Child(ren) Supplemental Life Coverage (Dependent Child Coverage Monthly Rate is $0.07 per $1,000 of coverage)

❑ **Coverage Amount Per Child $**_____ List any amount between $2,000 to $10,000 (in increments of $2,000) ❑ **Decline Coverage**

Dependent child(ren) coverage will end the last day in the year in which they turn age 19. Coverage continues until age 25 if full-time student (proof required).
The beneficiary for insurance on the lives of your dependent children will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions.

Dependent Child(ren) Full Name	Gender	Date of Birth (mm/dd/yyyy)	SSN	Full-Time Student
	❑ Male ❑ Female			❑ Yes ❑ No
	❑ Male ❑ Female			❑ Yes ❑ No
	❑ Male ❑ Female			❑ Yes ❑ No

Employee Monthly Supplemental Life Insurance Rate Table (per $1,000 of coverage)

Age Bands	< 25	25 - 29	30 – 34	35 – 39	40 – 44	45 – 49	50 – 54	55 – 59	60 – 64	65 – 69	70 +
Employee Rate	$0.08	$0.08	$0.11	$0.13	$0.19	$0.27	$0.38	$0.70	$0.80	$1.28	$2.07

Your Supplemental Life Insurance benefit will be reduced by 35% on the date you attain age 66 and 50% when you attain age 70.
Your Supplemental Life Insurance premium will continue to increase as you age. This will be based on the age chart above.

Beneficiary Information: You must select your beneficiary – the person(s) or legal entity(ies) who receives a benefit payment if you die while covered by this plan. Please make sure you name a contingent beneficiary – the person(s) or legal entity(ies) who will 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, you must show the percentage of your benefit to be paid to each beneficiary. Please provide all 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, please contact your local benefits administrator or your own legal advisor. A primary beneficiary is the beneficiary or beneficiaries that you name to receive the benefits if they are living at the time of your death. The primary beneficiaries are the first in line to receive death benefits. Contingent beneficiaries, or secondary beneficiaries, are those named to receive the insurance proceeds if no primary beneficiary is alive at the time of your death.

Primary Beneficiary Designation – Employees reserve the right to change this beneficiary designation for supplemental life at any time upon written request.					
Name #1:	DOB:	SSN:		Relationship:	Percentage:
Address:	City:		State:	Zip:	Phone:
Name #2:	DOB:	SSN:		Relationship:	Percentage:
Address:	City:		State:	Zip:	Phone:
Contingent Beneficiary Designation – If the beneficiary dies before me, I designate as contingent beneficiary:					
Contingent #1:	DOB:	SSN:		Relationship:	Percentage:
Address:	City:		State:	Zip:	Phone:
Contingent #2:	DOB:	SSN:		Relationship:	Percentage:
Address:	City:		State:	Zip:	Phone:

- **For additional beneficiaries, please attach a separate list and include the names, addresses, dates of birth, and relationship to the employee.**
- **This plan includes Suicide Exclusion for employee and dependents. It applies to coverage amounts which become effective within two years of the date of death.**

Participant Confirmation Statement: By signing below, I acknowledge that I have been given the opportunity to enroll in the insurance coverage offered by my employer. I understand and agree that if I decline coverage now, but later decide to enroll, I may 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 Insurance Company. I also understand that as I age, my premium rate will increase based on the Supplemental Life rates table. 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 my employer can fully describe the provisions, terms, conditions, limitations, and exclusions of my 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. I authorize payroll deductions from my wages to cover my cost of coverage when applicable.

Employee (Participant) Signature: _____ **Print Name:** _____ **Date:** _____

EMPLOYER INFORMATION:

Institution Name: _____ **Institution/Department #:** _____/_____ **Division Code:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Employer Contact Phone Number: _____ **Employer Contact Email Address:** _____

Employer Signature: _____ **Employer Print Name:** _____ **Date:** _____

ADMINISTRATORS: Please send completed form to Employee Benefit Connections at ebc@archny.org. **For any questions or further assistance, please call (646)794-3060.**