ARCHDIOCESE OF ST. LOUIS

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

Hartford Customer Service 1.800.523.2233
Policy # 677885

Voluntary Life Insurance Enrollment/Change Form

For Employer Use Only:

Parish/School/Agency Location #:_____
Employer Name: _____
Contact Person: _____

☐ **Enroll** ☐ **Change** ☐ **Cancel** **Effective Date**_____

A *Personal Health Application* needs to be completed in addition to this enrollment/change form, if the employee is increasing coverage or adding Spouse Life outside of the first 31 days of hire or benefit eligibility.

Employee Name: _____

Social Security #: _____

Occupation: _____

Gender: ☐ Female ☐ Male

Marital Status: ☐ Single/Widowed/Divorced ☐ Married

Date of Hire: _____

Voluntary Life Insurance - Employee

You have the opportunity to enroll in Archdiocese of St. Louis's Voluntary Life Insurance plan. You may elect coverage in **$10,000** increments up to a maximum of $300,000. **If you are a new hire and enrolling within 31 days of your date of hire, you are guaranteed coverage up to $100,000. If you elect coverage greater than $100,000, you are required to complete a *Personal Health Application* and be approved for the extra coverage. If you are enrolling after your 31 day enrollment period, you are considered a late enrollee and will need to complete a *Personal Health Application* and be approved for any amount of coverage.**

Use the rate chart and calculation line below to determine your monthly cost for this coverage. The following costs should be calculated based on your age.

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	.06	.068	.073	.101	.142	.242	.417	.641	.901	1.271	1.986

☐ I elect to **enroll** in the Voluntary Life plan at the monthly cost below.

_____ ÷ $1,000 = _____ x _____ = $_____

Elected Benefit Amount in $10,000 Increments | Rate Above | My Monthly Cost

☐ I elect to **decline** the Voluntary Life plan.

Note: Benefits will automatically reduce to 65% of your elected amount on July 1 following the date you turn age 70, to 45% at age 75 and to 30% at age 80.

Voluntary Life Insurance – Spouse

If you elect the Voluntary Life Insurance for yourself, you may elect Voluntary Life Insurance for your Spouse. Your election may be made in increments of **$5,000** to a maximum of $150,000 but may not exceed 50% of your approved election. If you are a timely applicant, your spouse is guaranteed coverage up to $25,000. If electing coverage as a late enrollee or over $25,000, a *Personal Health Application* will need to be completed and approved before coverage is effective.

Voluntary Spouse rates and premiums are based on the employee's age not the spouse's age. Use the rate chart and calculation line below to determine your monthly cost for this coverage.

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	.06	.068	.073	.101	.142	.242	.417	.641	.901	1.271	1.986

☐ I elect to **enroll** my Spouse in the Voluntary Life plan at the monthly cost below.

_____ ÷ $1,000 = _____ x _____ = $_____

Elected Benefit Amount in $5,000 Increments | Rate Above | My Monthly Cost

☐ I elect to **decline** the Voluntary Life plan for my Spouse.

Spouse First Name	Spouse Last Name	Gender	Marriage Date	Birth Date	Social Security#

Voluntary Life Insurance - Child(ren)

If you elect the Voluntary Life Insurance for yourself, you may elect Voluntary Life coverage for your Dependent Child(ren). Your election may be made in increments of $5,000 to a maximum of $15,000. Children are covered from age 14 days to their 26th birthday regardless of student status.

The monthly cost for children is $1.00 per $5,000 unit of coverage. One premium will insure all your eligible children, regardless of the number of children you have.

☐ I elect to **enroll** my dependent child(ren) in the Voluntary Life plan at the monthly cost below.

_____ ÷ $5,000 = _____ x $0.93 = $_____

Elected Benefit Amount | Rate | My Monthly Cost

☐ I elect to **decline** the Voluntary Life plan for my dependent child(ren).

Child First Name	Child Last Name	Gender	Birth Date	Social Security#

Employee Confirmation

I have been given the opportunity to enroll in Archdiocese of St. Louis's Group Voluntary Life Insurance plan. 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 Hartford Life and understand my request for coverage may be denied.

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

Signature: _____ **Date:** _____

Email: _____

Instructions: 1. Please fax or give the completed form to your Benefits Administrator at your parish/office/agency/school.
2. Keep a copy for your records.