**GROUP BENEFITS** 

## Le Moyne College Benefits Enrollment Form



## **Information About You**

Name: 35	5513-0	Social Security Number / Employee ID Number:
Date of Birth:		Date of Hire:
Salary:		Location/Department/Division:

## Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- Step 1: Please enter or check your coverage elections and details. You may only elect and will be covered for levels of coverage included in your employer's contract.
- Step 2: Please sign, date and return this form to Human Resources by 11/9/2012.

Supplemental Life and AD&D Insurance

You can purchase Supplemental Life and AD&D Insurance in increments of \$10,000. The maximum amount you can purchase cannot be more than \$500,000. If you are electing coverage for the first time, or electing to increase your current coverage, you will be required to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective. You may elect Life Insurance without electing AD&D, but you cannot elect AD&D without Life Insurance. The amount of AD&D must equal your approved Life Insurance election.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	0.0275	0.0315	0.0390	0.0545	0.0750	0.1195	0.1835	0.2995	0.4785	0.8405	1.5165	3.0710

	Nate	0.0273	0.0515	0.0000	0.00-0	0.0730	0.1133	0.1000	0.2333	0.4700	0.0400	1.0100	3.0710
T	o calculate	your Sem	i-monthly co	st, please ι	use the foll	owing form	ıula(s):						

X	Rate	= \$	
	Rale		My Semi-monthly Cost
_ of Life coverage.			
x	\$0.0115	= \$	My Semi-monthly Cost
	_	age.	x\$0.0115= \$

□   - ++	- f A D 0 D
☐ I elect to purchase \$	of AD&D coverage.

- ☐ I **decline** to purchase AD&D coverage.
- ☐ I elect to **continue** my current AD&D coverage.

Spouse Supplemental Life and AD&D Insurance

If you purchase Supplemental Life and AD&D Insurance, you can purchase Spouse Supplemental Life and AD&D Insurance in increments of \$5,000. The maximum amount you can purchase cannot be more than the lesser of \$100,000 or 50% of your Employee Voluntary/Supplemental Life Insurance coverage. If you are electing coverage for the first time, or electing to increase your current coverage, your Spouse will be required to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective. You may elect Life Insurance without electing AD&D, but you cannot elect AD&D without Life Insurance. The amount of AD&D must equal your approved Life Insurance election.

Costs are based on your Spouse's age.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including issuing companies Hartford Life Insurance Company and Hartford Life and Accident Insurance Company. Policies sold in New York are underwritten by Hartford Life Insurance Company. Home Office of both companies: Simsbury, CT. All benefits are subject to the terms and conditions of the policy. Policies underwritten by the issuing companies listed above detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in force or discontinued.

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Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-6	9   70-74	75+
Rate	0.0625	0.0520	0.0570	0.0785	0.1130	0.1765	0.2750	0.4220	0.7215	1.230	0 2.1965	4.3960
	te your Semi-r	nonthly co		use the fol	the following formula(s): x= \$						monthly Co	st
□ I elect to purchase \$of Life coverage. □ I decline to purchase Life coverage. □ I elect to continue my current Life coverage.												
		÷ \$1,000	) =				\$0.0115		- <b>c</b>			
AD&D B	enefit Amount				x		Rate		= \$N	/ly Semi-	monthly Co	st
□ I decline to purchase AD&D coverage. □ I elect to continue my current AD&D coverage.												
	First Na	me			Last N	lame		Gender	Date of	Birth	Date of	Marriage
Child(ren) Supplemental Life and AD&D Insurance  If you purchase Supplemental Life and AD&D Insurance, you can purchase Child(ren) Supplemental Life and AD&D Insurance for your Dependent Child(ren) between the ages of Live Birth and 19 years (26 years if a full time student), in the amount(s) of \$10,000. Child(ren) between the ages of Live Birth and 6 months are limited to coverage in the amount of \$1,000. You may elect Life Insurance without electing AD&D, but you cannot elect AD&D without Life Insurance. The amount of AD&D must equal your approved Life Insurance election.												
□ I declin	purchase \$ e to purchase c continue my	Life cover	age.		mi-monthly	y cost of \$1	.88 (cost i	s for all cov	ered Child	ren).		
AD&D	Benefit Amou	÷ \$1,0	000 =				(	\$0.0115 Rate	=	: \$	y Semi-mon	thly Cost
□ I elect to	p purchase \$_e to purchase	AD&D cov			.D&D cove	rage.		. 1310			, 22	, 200t
	First	Name				Las	t Name			Date	of Birth	Gender
	0											

East Name	Date of Birtin	Oction

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primary or conti requested below	re your beneficiary designgent beneficiary, show to lifyour beneficiary is not ance, contact your benef	ot related either by blood	nefit to be paid to eacl or by marriage, insert	h heneficiary Please r	provide all of the	information
	Full Name	Address	Social Security #	Relationship	Date of Birth	Percentage
Primary Beneficiary						
Contingent Beneficiary						
request.  Spousal Consei Nevada, New N his or her rights  This will certify the seneficiaries of	e spouse and children, sunt For Community Proper lexico, Texas, Washingto to any community prope that, as spouse of the Emgroup life insurance under unnity property laws. I un	ty States Only: If you live n, or Wisconsin – you ma rty interest in the benefit. aployee named above, I her the above policy and w	in a community prope y complete the Spous Disclaimer: Spousal c ereby consent to my s aive any rights I may b	erty state – Arizona, Ca al Consent section, who onsent does not apply spouse designating the have to the proceeds of	alifornia, Idaho, L nich allows your to ERISA plans e person(s) listed of such insurance	ouisiana, spouse to waive dabove as a under
Signature of En	nployee's Spouse:			Date:		
	on hat I have been given the Le Moyne College.	e opportunity to enroll in t	he Life Insurance cove	erage described in the	Benefit Highligh	t Sheets and
I understand an satisfactory to T denied by The I	d agree that if I decline c he Hartford and be appro Hartford.	overage now, but later de oved for such coverage b	ecide to enroll, I will be efore it becomes effec	required to provide extive. I understand my	vidence of insura request for cove	bility that is rage may be
the insurance perovisions, term	d agree that insurance wolicy. I understand and aque, conditions, limitations ce policy, I agree to be be	gree that only the insuran and exclusions of your in	ce policy issued to the surance coverage. In t	policyholder (your en	nployer) can fully	describe the
the policy. If I ha	urance coverage with The ave disability income cover specified period starting a	erage with The Hartford, I	understand and agree	e that the maximum di	uration benefits a	are payable will
I authorize my e	employer to make the app	ropriate payroll deduction	ns from my earnings.			
I understand that employer.	at no insurance will be va	lid or in force if I am not e	eligible in accordance v	with the terms of the g	roup policy as is	sued to my
			Data			

Name:

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