

Voluntary Life Insurance



Benefit Highlights for

CAJON VALLEY UNION SD

What is voluntary life insurance?	<p>Voluntary life insurance is coverage that you pay for.</p> <p>Voluntary life insurance pays your beneficiary (please see below) a benefit if you die while you are covered.</p> <p>This highlight sheet is an overview of your voluntary life insurance.</p>
Am I eligible?	You are eligible if you are an active full time employee who works at least 20 hours per week on a regularly scheduled basis.
When can I enroll?	You can enroll during your scheduled enrollment period, within 31 days of the date you have a change in family status, or within 31 days of the completion of your eligibility waiting period as stated in your group policy.
When is it effective?	Coverage goes into effect subject to the terms and conditions of the policy. You must be actively at work with your employer on the day your coverage takes effect.
How much voluntary life insurance can I purchase?	You can purchase voluntary life insurance in increments of \$10,000. The maximum amount you can purchase cannot be more than the lesser of 5 times your annual earnings or \$300,000. Annual earnings are as defined in The Hartford's contract with your employer.
Am I guaranteed coverage?	If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of \$150,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your current coverage, you will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.
What is a beneficiary?	Your beneficiary is the person (or persons) or legal entity (entities) who receives a benefit payment if you die while you are covered by the policy. You must select your beneficiary when you complete your enrollment application; your selection is legally binding.
Are there other limitations to enrollment?	If you do not enroll within 31 days of your first day of eligibility, you will be considered a late entrant. Typically, late entrants may need to show evidence of insurability and may be responsible for the cost of physical exams or other associated costs if they are required.

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Spouse Voluntary Life Insurance (includes domestic partner)	<p>If you elect voluntary life insurance for yourself - You may choose to purchase spouse voluntary life insurance in increments of \$5,000, to a maximum of \$100,000. Spouse voluntary life insurance terminates at age 70.</p> <p>Coverage cannot exceed 50% of the amount of your employee voluntary/supplemental life insurance coverage. You may not elect coverage for your spouse if they are in active full-time military service or is already covered as an employee under this policy.</p> <p>If your spouse is confined in a hospital or elsewhere because of disability on the date his or her insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days.</p> <p>If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of \$50,000, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before the excess can become effective. If you were previously eligible and are electing coverage for the first time or electing to increase your spouse's current coverage, your spouse will need to provide evidence of insurability that is satisfactory to The Hartford before coverage can become effective.</p>
Child(ren) Voluntary Life Insurance	<p>If you elect voluntary life insurance for yourself, you may choose to purchase child(ren) voluntary life insurance coverage in the amount(s) listed below – no medical information is required. Coverage cannot exceed 50% of the amount of your employee voluntary life insurance coverage.</p> <ul style="list-style-type: none"> • Option 1: \$2,500 (covers all children) • Option 2: \$5,000 (covers all children) • Option 3: \$10,000 (covers all children) <ul style="list-style-type: none"> • If your dependent child is confined in a hospital or elsewhere because of disability on the date his or her insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days. <ul style="list-style-type: none"> • Child(ren) must be not yet age 26 or meet certain other conditions to be covered. • Unmarried child(ren) over age 26 may be covered if they are disabled and primarily dependent upon the employee for financial support.
Does my coverage reduce as I get older?	<p>Your benefit will be reduced by 50% at age 70. All coverage cancels at retirement.</p>

<p>Can I keep my life coverage if I leave my employer?</p>	<p>Yes, subject to the contract, you have the option of:</p> <ul style="list-style-type: none"> • Converting your group life coverage to your own individual policy (policies). • If you leave your employer, portability is an option that allows you to continue your life insurance coverage. To be eligible, you must terminate your employment prior to Social Security normal retirement age. This option allows you to continue all or a portion of your life insurance coverage under a separate portability term policy. Portability is subject to a minimum of \$5,000 and a maximum of \$250,000 and does include coverage for your spouse and child(ren). To elect portability, you must apply and pay the premium within 31 days of the termination of your life insurance. Evidence of insurability will not be required. <p>Dependent spouse portability is subject to a maximum of \$50,000.</p> <p>Dependent child(ren) portability is subject to a maximum of \$10,000.</p>
<p>What is the living benefits option?</p>	<p>If you are diagnosed as terminally ill with a life expectancy of 12 months or less, you may be eligible to receive payment of a portion of your life insurance. The request cannot exceed 80% of the in force amount of life insurance, and is subject to a minimum of \$3,000 and a maximum \$240,000. The remaining amount of your life insurance would be paid to your beneficiary when you die.</p>
<p>Do I still pay my life insurance premiums if I become disabled?</p>	<p>If you become totally disabled before age 60 and your disability lasts for at least 9 months, your life insurance premium may be waived. The premium for your dependent's coverage will also be waived if you are disabled and approved for waiver of premium. Coverage for your dependents will end if the policy terminates.</p>

Important Details

As is standard with most term life insurance, this insurance coverage includes certain limitations and exclusions:

- the amount of your coverage may be reduced when you reach certain ages.
- death by suicide (two years).

Other exclusions may apply depending upon your coverage. Once a group policy is issued to your employer, a certificate of insurance will be available to explain your coverage in detail.

This benefit highlights sheet is an overview of the insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the benefit highlights sheet and the insurance policy, the terms of the insurance policy apply.

HARTFORD LIFE AND ACCIDENT INSURANCE COMPANY

One Hartford Plaza, Hartford, CT 06155
(A stock insurance company)

**Benefits Enrollment Form****Instructions**

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

- **Step 1:** Please **enter and/or check** your coverage elections. Make sure the coverage amount that you elect includes your existing coverage amount. 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 **Benefits Office**.

District Name: CAJON VALLEY UNION SD			Policy #875129		
Employee Name:			Social Security Number:		Effective Date:
Date of Birth:					
Date of Hire:					
Annual Salary:					

Dependent Information			If more than 4 child(ren), attach additional sheet.		
Spouse Name (includes domestic partner):		Gender:	Spouse Date of Birth:	Date of Marriage or Eligible Partnership:	
		<input type="checkbox"/> M <input type="checkbox"/> F			
Child Name:	Gender:	Date of Birth:	Child Name:	Gender:	Date of Birth:
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	
	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> M <input type="checkbox"/> F	

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Voluntary Life Insurance

Your cost may change when you move into a new age category.

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	\$0.6000	\$0.6000	\$0.8400	\$1.0800	\$1.3200	\$2.4000	\$4.2000	\$7.0800	\$11.4000	\$16.0800	\$23.7600	\$23.7600

To calculate your tenthly cost, please use the following formula(s):

$$\frac{\text{Life Benefit Amount}}{\text{Divided by } \$10,000} = \text{Rate} \times \text{Tenthly Cost}$$

- ☐ I elect to **purchase** \$_____ of life coverage.
☐ I **decline** to purchase life coverage.
☐ I elect to **continue** my current life coverage.

Spouse Voluntary Life Insurance

Costs are based on your spouse's age. Your cost may change when your spouse moves into a new age category.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
Rate	\$0.3000	\$0.3000	\$0.4200	\$0.5400	\$0.6600	\$1.2000	\$2.1000	\$3.5400	\$5.7000	\$8.0400

To calculate your tenthly cost, please use the following formula(s):

$$\frac{\text{Life Benefit Amount}}{\text{Divided by } \$5,000} = \text{Rate} \times \text{Tenthly Cost}$$

- ☐ I elect to **purchase** \$_____ of life coverage.
☐ I **decline** to purchase life coverage.
☐ I elect to **continue** my current life coverage.

Child(ren) Voluntary Life Insurance

- ☐ I elect to purchase \$10,000 of life coverage at a tenthly cost of \$1.00 (cost is for all covered children).
☐ I elect to purchase \$5,000 of life coverage at a tenthly cost of \$0.50 (cost is for all covered children).
☐ I elect to purchase \$2,500 of life coverage at a tenthly cost of \$0.25 (cost is for all covered children).
☐ I **decline** to purchase life coverage.
☐ I elect to **continue** my current life coverage.

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Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. Please make sure that you also name a contingent beneficiary – who would 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, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of 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, contact your benefits administrator or your own legal advisor.

This beneficiary designation will be for ALL group life or accidental death insurance coverage issued by The Hartford for you. 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 you die.

PRIMARY BENEFICIARY

Primary Beneficiary Name:	Social Security #:	Date of Birth:	Relationship:	Percentage:
Address:			Phone Number:	
Primary Beneficiary Name:	Social Security #:	Date of Birth:	Relationship:	Percentage:
Address:			Phone Number:	

CONTINGENT BENEFICIARY

Contingent Beneficiary Name:	Social Security #:	Date of Birth:	Relationship:	Percentage:
Address:			Phone Number:	
Contingent Beneficiary Name:	Social Security #:	Date of Birth:	Relationship:	Percentage:
Address:			Phone Number:	

The beneficiary for insurance on the lives of your dependents will automatically be you, if surviving. Otherwise, the beneficiary will be subject to policy provisions. A beneficiary for employee life or accidental death insurance may be changed upon written request.

Consent For Community Property States Only: If you live in a community property state – **Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Texas, Washington, and Wisconsin** – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. **Disclaimer:** Spousal consent does not apply to ERISA plans. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will represent that, as spouse of the employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ Date: _____

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Name: _____

Confirmation

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 Hartford.

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.

If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit(s) reduce at a specified age(s) stated in the policy.

I authorize payroll deductions from my wages to cover my cost of coverage when applicable. I understand rates and benefits may be changed by the insurer.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are required by The Hartford or by law and are not met, the policy will not be implemented and the coverage I have elected will not be in force.

Fraud Notice(s)

For Residents of Louisiana and Maryland:

Any person who knowingly (knowingly or willfully in Maryland) presents a false or fraudulent claim for payment of a loss or benefit or knowingly (knowingly or willfully in Maryland) presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Residents of New York (Not applicable to Life Insurance):

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Residents of Virginia:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signed _____ Date _____

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