GROUP BENEFITS

The Board of Stark County Commissioners
Benefits Enrollment Form - Supplemental Life/AD&D

THE HARTFORD

Information About You

Name:	**Social Security Number:**
Date of Birth:	**Date of Hire:**

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 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.

Supplemental Life and AD&D Insurance

You can purchase Supplemental Life and AD&D Insurance in the amount(s) of $10,000, $25,000, $50,000, $75,000, $100,000, $200,000 or $300,000. If you are enrolling within 31 days from when you are first eligible, you may elect up to $100,000, without providing evidence of insurability. If you are currently participating in this coverage, you may increase your current coverage by 1 level at your employer's next annual enrollment period, not to exceed $100,000 without providing evidence of insurability. If you were previously eligible for coverage and opted out, you may elect coverage in the amount of $10,000 at your employer's next annual enrollment period, without providing evidence of insurability.

Monthly Cost for Supplemental Life and AD&D Insurance

Coverage Amount	$10,000	$25,000	$50,000	$75,000	$100,000	$200,000	$300,000
Monthly Cost	$4.05	$10.13	$20.25	$30.38	$40.50	$81.00	$121.50

- ○ I elect to **purchase** the total amount of $_____ in Life and AD&D coverage.
- ○ I **decline** to purchase Life and AD&D coverage.

Prepare Today.
Help Protect Tomorrow.

Name: _____

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. **This beneficiary designation will be for Supplemental Life and Accidental Death insurance issued by The Hartford for you, unless specifically named otherwise.** 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.

	Full Name	Address	Social Security #	Relationship	Date of Birth	Percentage
Primary Beneficiary						
Contingent Beneficiary						

A beneficiary for employee Life Insurance may be changed at any time upon written request.

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life Insurance coverage offered through the Board of Stark County Commissioners.

I understand and agree that if I decline coverage now, but later decide to enroll, I may enroll only during an Annual Enrollment Period designated by the Policyholder.

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 the policyholder (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 my employer to make the appropriate payroll deductions from my earnings.

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 not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed _____ Date _____