GROUP BENEFITS

San Diego State University Foundation
Benefits Enrollment Form

Information About You

Name:	**Title**
Date of Birth:	**Date of Hire:**
Annual Salary:	**Work Phone Number:**
Work Email:	

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 Insurance

You can purchase Supplemental Life Insurance in increments of $10,000. The maximum amount you can purchase cannot be more than $500,000. If you are newly eligible and elect an amount that exceeds the guaranteed issue amount of $200,000, you will need to provide evidence of insurability that is satisfactory to The Hartford before the excess amount can become effective. If you were previously eligible and are now electing coverage for the first time, you will need to provide evidence of insurability that is satisfactory to The Hartford before any coverage can become effective. If you are electing to increase your current coverage, you will need to provide evidence of insurability that is satisfactory to The Hartford before any additional coverage can become effective.

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	0.03	0.03	0.04	0.06	0.09	0.13	0.22	0.38	0.51	0.81	1.43	2.56

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

________________ ÷ $1,000 = ____________ x ____________ = $ ________________

Life Benefit Amount | Rate | My Monthly Cost

- ☐ I elect to **purchase** the total amount of $__________ of Life coverage.
- ☐ I **decline** to purchase Life coverage.
- ☐ I elect to **continue** my current Life coverage.
- ☐ I elect to **increase** my current Life coverage of $__________ by $_________ for a total benefit amount of $__________.

Spouse/Domestic Partner Supplemental Life Insurance

If you purchase Supplemental Life Insurance, you may purchase Spouse/Domestic Partner Supplemental Life Insurance in the amount of $25,000. Spouse/Domestic Partner coverage cannot exceed 100% of your Employee Supplemental Life Insurance. If your Spouse or Domestic Partner is newly eligible, this coverage is provided without requiring evidence of insurability. If your Spouse or Domestic Partner was previously eligible and you are now electing Spouse/Domestic Partner coverage for the first time, your Spouse or Domestic Partner will need to provide evidence of insurability that is satisfactory to The Harford before any coverage can become effective. Costs are based on Employee's age.

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	0.03	0.03	0.04	0.06	0.09	0.13	0.22	0.38	0.51	0.81	1.43	2.56

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

$25,000 ÷ $1,000 = 25 x ____________ = $ ________________

Life Benefit Amount | Rate | My Monthly Cost

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Name: ____

☐ I elect to **purchase** the total amount of $__________ of Spouse/Domestic Partner Life coverage.
☐ I **decline** to purchase Spouse/Domestic Partner Life coverage.
☐ I elect to **continue** my current Spouse/Domestic Partner Life coverage.

Spouse or Domestic Partner First Name	Spouse or Domestic Partner Last Name	Gender	Date of Birth	Date of Marriage or Eligible Partnership

Child(ren) Supplemental Life Insurance

If you purchase Supplemental Life Insurance, you may purchase Child(ren) Supplemental Life Insurance for your Dependent Child(ren) between the ages of Live Birth and 25 years in the amount of $5,000.

$5,000	÷ $1,000 =	5	x	0.1500	x		=	$
Life Benefit Amount				Rate		# of Covered Children		My Monthly Cost

☐ I elect to **purchase** the total amount of $5,000 of Child Life coverage.
☐ I **decline** to purchase Child Life coverage.
☐ I elect to **continue** my current Child Life coverage.

Child(ren) First Name	Child(ren) Last Name	Date of Birth	Gender

Family Voluntary Accidental Death & Dismemberment Insurance

You can purchase Family Voluntary Accidental Death & Dismemberment Insurance in increments of 1 times your annual Earnings up to 10 times your annual Earnings, rounded to the next higher $1,000. The maximum amount you can purchase cannot be more than the lesser of 10 times your annual Earnings or $500,000.

You can also purchase coverage for your Spouse / Domestic Partner or Child(ren) at the percentages of your election outlined in the following chart:

Family Member(s) Covered:	Employee Only	Employee & Spouse or Domestic Partner Only	Employee & Child(ren) Only	Employee, Spouse or Domestic Partner & Child(ren)
Percent of Benefit Paid:	100%	100% for Employee 50% for Spouse or Domestic Partner	100% for Employee 15% for each Child	100% for Employee 40% for Spouse or Domestic Partner 10% for each Child

Coverage Options	Monthly Rate
Myself Only	0.016
Myself and My Family	0.023

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Name: ____

	I Elect AD&D in the total amount of:		I Elect AD&D in the total amount of:
☐	1 X Earnings	☐	6 X Earnings
☐	2 X Earnings	☐	7 X Earnings
☐	3 X Earnings	☐	8 X Earnings
☐	4 X Earnings	☐	9 X Earnings
☐	5 X Earnings	☐	10 X Earnings

______________ ÷ $1,000 = ______________ x 0.016 = $ ______________

Elected Benefit Amount (Employee Coverage Amount Only) — Rate — My Monthly Cost

______________ ÷ $1,000 = ______________ x 0.023 = $ ______________

Elected Benefit Amount (Employee and Family Coverage Amount Only) — Rate — My Monthly Cost

☐ I elect to **purchase** the total amount of $______________ in AD&D coverage for myself only.
☐ I elect to **purchase** the total amount of $______________ in AD&D coverage for myself and my family, who will be covered at the percentages of my election listed above.
☐ I elect to **continue** my current AD&D coverage.
☐ I **decline to purchase** AD&D coverage.

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 ALL group life or accidental death insurance coverage 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	Percent-age
Primary Beneficiary						
Contingent Beneficiary						

The beneficiary for insurance on the lives of your spouse or domestic partner and children will automatically be you, if surviving. Otherwise, the beneficiary will be the estate of the spouse or domestic partner and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

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Name: ____

Spousal Consent For Community Property States Only: If you live in a community property state – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin – you may complete the Spousal Consent section, which allows your spouse or domestic partner to waive his or her rights to any community property interest in the benefit. Disclaimer: Spousal consent does not apply to ERISA plans.

This will certify that, as spouse or domestic partner of the Employee named above, I hereby consent to my spouse or domestic partner designating the person(s) listed above as beneficiaries of group life 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 or Domestic Partner: ________________________________ Date: ______________________________

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life and Accident insurance coverage described in the Benefit Highlight Sheets and offered through San Diego State University Foundation.

I understand and agree that if I decline coverage now, but later decide to enroll, I will 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 the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your 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 is reduced at a specified age stated in the policy. If I have disability income coverage with The Hartford, I understand and agree that the maximum duration benefits are payable will be limited to a specified period starting at a specified age and that a claim for benefits may not be approved for a pre-existing condition.

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 ________________________________

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