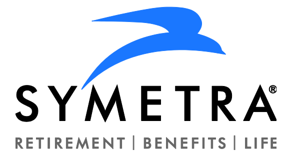
Benefits Enrollment Form



Indiana State University

01-016658-00

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 Staff Benefits Office, 300 Rankin Hall, Terre Haute, IN 47809 no later than __________. If you have any questions please contact Staff Benefits at (p) 812-237-4151; (f) 812-237-8084; email: ISU-SB@mail.indstate.edu.

Information About You

Name:	Date of Birth:	Date of Hire:
Basic Annual Earnings:	EE ID#:	Class:

Supplemental Life Insurance

You may purchase Supplemental Life Insurance in increments of $10,000 in any amount from a minimum of $10,000 up to $300,000. Any requested change in coverage and new elections outside of the original eligibility can only be made during the Annual Enrollment Period (Nov. 1 to Nov. 30) or within 31 days following a change in family status and will require Evidence of Insurability to be approved by Symetra.

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	$0.074	$0.074	$0.080	$0.104	$0.168	$0.294	$0.452	$0.766	$0.914	$1.738	$3.094	$4.582

For all Amounts available from the design of the plan, to determine your cost for coverage, please find your rate based on your age above at enrollment, and then use the calculation below to find your total cost in increments of $10,000 up to your maximum election of $300,000.

$ ____________________ ÷ 1,000 = $ ______________ x $ __________ = $ __________
(Life Benefit Amount) (Rate) (Monthly Cost)

☐ I elect to **purchase** the total amount of $________________ in Supplemental Life Insurance.

☐ I **decline** Supplemental Life Insurance.

Supplemental Spouse Life Insurance

You may purchase Supplemental Spouse Life Insurance in increments of $10,000 to any amount not to exceed 100% of the Employee benefit amount of Supplement Life coverage. Evidence of Insurability is required for all amounts. Supplemental Spouse Life Insurance is not available unless you purchase Supplemental Life Insurance.

Spouse	First name	Last name	Gender	Date of marriage	Date of birth
			☐ - Male ☐ - Female	/ /	/ /

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	$0.074	$0.074	$0.080	$0.104	$0.168	$0.294	$0.452	$0.766	$0.914	$1.738	$3.094	$4.582

For all Amounts available from the design of the plan, to determine your cost for coverage, please find your rate based on your spouse's age above at enrollment, and then use the calculation below to find your total cost in increments of $10,000 up to your maximum election of $300,000, not to exceed 100% of the Supplemental Life coverage.

$ ________________ ÷ 1,000 = $ ____________ x $ _________ = $ _________
Spouse Life Benefit Amount Rate Monthly Cost

☐ I elect to **purchase** the total amount of $________________ in Supplemental Spouse Life Insurance.

☐ I **decline** Supplemental Spouse Life Insurance.

Supplemental Child(ren) Life Insurance

You may elect Supplemental Life coverage for child(ren) ages 14 days to age 19, or 25 if a full time student, for coverage of $2,000, $5,000, or $10,000. Supplemental Child(ren) Life Insurance covers all children listed below. Supplemental Child(ren) Life Insurance is not available unless you purchase Supplemental Life Insurance.

Child(ren)	First name	Last name	Date of birth	Age
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	
			/ /	

Please ☒ your election below.

I elect Child Life in the total amount of and my benefit will be	My Monthly payroll cost will be
☐ $2,000	$ 0.40
☐ $5,000	$ 1.00
☐ $10,000	$ 2.00
☐ **I Decline Coverage**	**$0.00**

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 only group Supplemental Life or accidental death insurance coverage issued by Symetra Life Insurance Company 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.

Primary Beneficiary: The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

Contingent Beneficiary: The person or persons you want to receive the life insurance benefit if you die and if no primary beneficiary is alive on that date. If more than one contingent beneficiary has been named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

	Full name	Address	Social Security #	Date of birth	Relationship	% of benefit
☐ Primary						
☐ Primary ☐ Contingent						
☐ Primary ☐ Contingent						
☐ Primary ☐ Contingent						

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

Confirmation

I, the undersigned, an Employee of the above-named policyholder, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of the insurance **(Not applicable if the Employer pays 100% of the required contribution).**

I hereby waive my right at this time to elect the insurance coverages which I did not select above. I understand that if I do not enroll within 31 days, when first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death.

All information submitted by me on this form to the best of my knowledge and belief is true and complete.

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 subjects such person to criminal and civil penalties.

Signature____Date__________________________________

Group Benefits are insured by Symetra Life Insurance Company located at 777 108th Avenue NE, Suite 1200, Bellevue, WA 98004.
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