



Employee Enrollment Form

Supplemental Life and AD&D Insurance

Instructions: Submit the completed form to City of Eugene Benefits Staff via fax to 541-650-3031, encrypted email to BenefitsStaff@eugene-or.gov, or mail to 940 Willamette Street Suite 200, Eugene OR 97401.

To be completed by Benefits Staff

Name of Employer City of Eugene	Group/Plan Number GL-715287	EE Date of Hire	Coverage/Change Effective Date
Enrollment is due to (check all that apply): <input type="checkbox"/> Initial Eligibility <input type="checkbox"/> Enrolling After Initial Eligibility Period <input type="checkbox"/> Change in Coverage Amount <input type="checkbox"/> Add Child Life Coverage <input type="checkbox"/> Other (list): _____			

EMPLOYEE INFORMATION: To be completed by Employee

Employee Name (FIRST MI LAST)	Employee ID #	Date of Birth
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EMPLOYEE COVERAGE: Review the insurance policy or benefit highlight summary prior to electing coverage.

Guaranteed Issue	<p>When you are first eligible for Supplemental Life coverage, you can elect up to the Guaranteed Issue (GI) Limit without proof of good health. GI is available for employee only within 31 days of hire date, or if offered and elected during a Special Enrollment Period.</p> <ul style="list-style-type: none"> • Guaranteed Issue (GI) Limit = \$150,000
Supplemental Life Election	<p>I am eligible and applying for Guaranteed Issue coverage of: \$ _____ (A) I currently have City of Eugene Supplemental Life coverage of: \$ _____ (B) I am applying for new or additional Supplemental Life coverage of: \$ _____ (C) Total Supplemental Life coverage ((A) + (B) + (C)): \$ _____</p> <p>Total Supplemental Life coverage is available from \$20,000 to \$500,000, in \$10,000 increments. Amounts not qualifying for Guaranteed Issue require an Evidence of Insurability form and are subject to approval by The Hartford. The benefit amount available is subject to a reduction schedule beginning at age 70.</p>
Accidental Death & Dismemberment (AD&D) Election	<input type="checkbox"/> Waive <input type="checkbox"/> Amount equal to Supplemental Life coverage.

CHILD LIFE COVERAGE

Child Life	<p>Supplemental Life coverage is required to elect Child Life. Either the employee or the spouse/DP may cover eligible dependent children, but not both. Child Life coverage is available from live birth up to age 26 years (or older if disabled prior to age 26).</p>
Child Life Election	<input type="checkbox"/> Waive <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 <p>The benefit elected above is payable for each eligible child. A single applicable premium amount covers all eligible children.</p>

BENEFICIARY INFORMATION: Please ensure your beneficiary designation is clear so there are no questions of your intent. The percentages must total 100% for all Primary Beneficiaries and 100% for all Contingent Beneficiaries, if applicable. Please use and attach additional sheets if needed.

Beneficiary: Benefits are paid first to ALL primary beneficiaries, if living when benefits become payable.		
Name of Beneficiary (FIRST MI LAST)	Relationship to You	Benefit %
Address (STREET, CITY, STATE, ZIP)	Phone Number	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
Name of Beneficiary (FIRST MI LAST)	Relationship to You	Benefit %
Address (STREET, CITY, STATE, ZIP)	Phone Number	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
Name of Beneficiary (FIRST MI LAST)	Relationship to You	Benefit %
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Name of Beneficiary (FIRST MI LAST)	Relationship to You	Benefit %
Address (STREET, CITY, STATE, ZIP)	Phone Number	<input type="checkbox"/> Primary <input type="checkbox"/> Contingent

READ THIS INFORMATION CAREFULLY AND THEN SIGN AND DATE BELOW

- I authorize my employer to deduct from my wages the premium, if any, for the elected coverage.
- I understand and agree that:
 - 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; and
 - My insurance will go into effect and remain in effect only in accordance with the provisions, terms, conditions, and exclusions of the insurance policy issued to my employer; and
 - In the event of any difference between the enrollment form and the insurance policy, I will be bound by the insurance policy.
 - 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 is subject to a denial and/or reduction in insurance benefits and may be subject to any civil penalties available.

Employee Signature	Date Signed
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Benefit Staff Use

Product(s)	Census	PS	PR	EE