LIFE INSURANCE ENROLLMENT/CHANGE FORM

(*Please print or type*)

☐ **ENROLLMENT** ☐ **CHANGE** Effective Date of Coverage or Change _____/_____/_____

School Unit _____ Employee's Name (*Last, First, M.I.*) _____

Social Security # _____-_____-_____ Date of Birth ____/____/____ Sex (*Please Circle*) M F Occupation _____

Address _____
(*Street*) (*City*) (*State*) (*Zip*)

Home Telephone ( ) _____-_____ Work Telephone ( ) _____-_____

❑ New Enrollee Date Hired _____/_____/_____
❑ Termination Date _____/_____/_____
❑ Retired Date _____/_____/_____

❑ Single
❑ Married

Annual Income (*Employer Must Complete*)

$ _____

Life & Accidental Death & Dismemberment– Choose only one

❑ Annual earnings
❑ 2 X annual earnings
❑ 3 X annual earnings
❑ 4 X annual earnings

Note: If you select 3 or 4 X annual earnings you are required to fill out a health questionnaire. This needs to be approved by underwriting before coverage will be effective.

Beneficiary Designation

Name (*Last, First, M.I.) (primary) /Social Security #* **(must equal 100%)** Relationship %

_____ _____ _____
_____ _____ _____
_____ _____ _____

If the above beneficiaries are not living, then pay:

_____ _____
(contingent)

Dependent Group Life Insurance

	☐ **Plan A**	☐ **Plan B**
Spouse	$5,000	$10,000
Children		
Attained age at death		
Age 14 days to 19 years	$5,000	$ 5,000
(or to and including age 25 if a full-time student)		

Note: *Dependent life insurance may be purchased only if the amount of the insurance for the covered spouse or child does not exceed 50% of the employee's total insurance.*

*****Subscribers may not elect dependent A or dependent B coverage for a spouse who is also a covered employee or who becomes a covered employee.

❑ I hereby authorize my employer to deduct from my earnings any payments, if applicable, for this coverage.

❑ I have declined all or a portion of the employee and/or dependent coverages. I understand that the Insurer has the right to require, at my expense, evidence of insurability for life insurance only in order to consider my request to change this decision, and that my request may be denied.

Fraud Statement *Any person who knowingly and with intent to defraud any insurance company or other person files a 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.*

Employee Signature _____ Employer Signature _____ Date Signed _____

MAINE SCHOOL MANAGEMENT ASSOCIATION
GROUP TERM LIFE, AD & D AND DEPENDENT LIFE INSURANCE
UNDERWRITTEN BY AETNA

Our group life insurance and accidental death & dismemberment insurance program is offered through Aetna exclusively for school employees and their families.

Who is Eligible?
This voluntary benefit is available to full time employees who regularly work at least 12-1/2 hours each week if you are a salaried employee or 16 hours each week if you are an hourly paid employee.

When Does Coverage Start?
If you are a newly hired employee, you become eligible for coverage the first of the month following your date of employment.

How Much Coverage Can I Purchase?
You can purchase voluntary term life up to 2 times your annual salary without proving insurability (filling out a health insurance questionnaire). Coverage is also available for spouses and any unmarried dependent children under age 25.

Can this benefit be part of my "cafeteria plan"?
Yes, but paying the premium pre-tax will result in the benefit being taxable.

May I sign up at a later date if I don't sign up now?
If you sign up more than 31 days after your initial eligibility date you must pass medical underwriting and you may be turned down for any coverage. Increasing your original coverage must also pass medical underwriting.

If I leave employment can I convert to an individual policy?
Yes, if you call Aetna Customer Service at 1-800-523-5065 (press #2) information will be sent to you regarding conversion details. This must be done during the 31 days following termination of employment.

What Does My Coverage Cost?

2017-2018 Rates

AGE		**EMPLOYEE** *Monthly rate per $1,000 of coverage*
Under 34		$0.071
35 - 44		$0.084
45 - 54		$0.138
55 - 64		$0.354
65 - 74		$0.913
75 and over		$1.318
Dependent Coverage Option #1	$5,000 Spouse Unmarried child(ren) Age 6 months to 19 years* = $5,000 Age 14 days but less than 6 months = $1,000	$2.18 per month (this includes all children)
Dependent Coverage Option #2	$10,000 Spouse Unmarried child(ren) Age 6 months to 19 years* = $5,000 Age 14 days but less than 6 months = $2,500	$3.87 per month (this includes all children)

*Any other unmarried child under age 25 who goes to school on a regular basis and depends solely on you for support will be covered as a dependent. (SOC 9A ISSUE DATE 6/27/01 AS RECORDED ON ESW)
Please see the insurance certificate for eligibility and coverage details