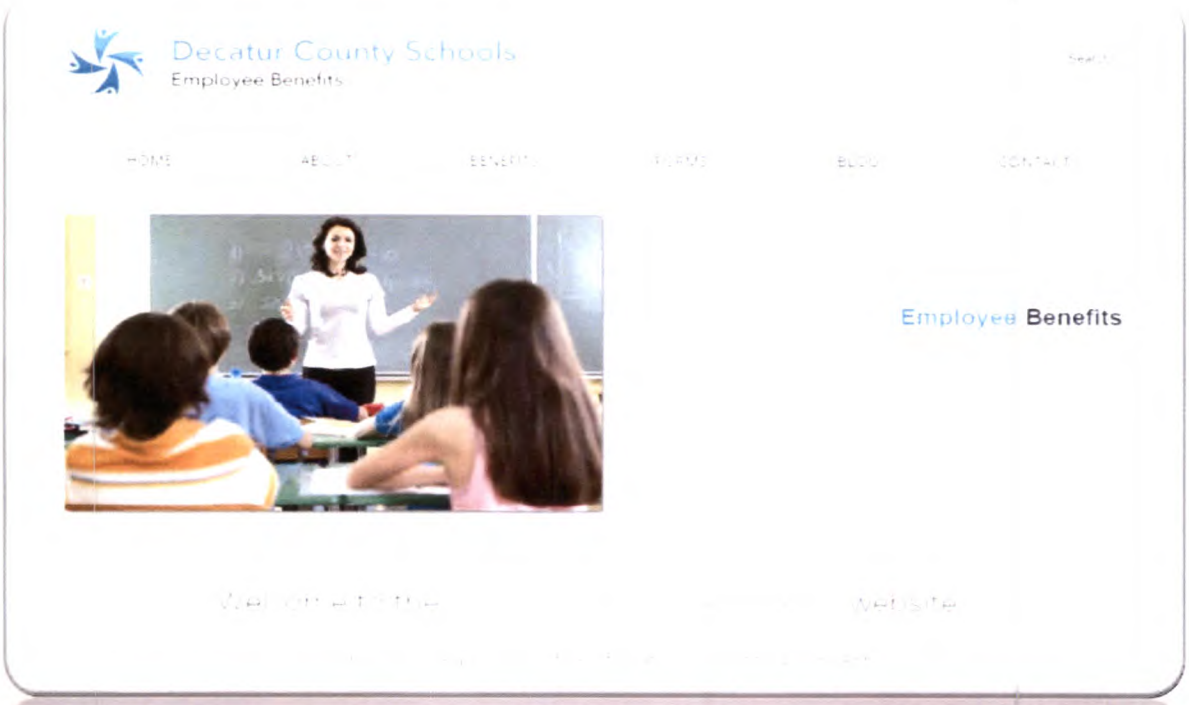
Decatur County Board of Education

New Employee Orientation



Employee Benefit Book

This booklet contains information on Insurance Benefits for you as a new employee of the Board of Education. The booklet will have a Summary Heading, Application, Evidence of Insurability (If Needed) and Summaries. Should you need additional information, you may access information on the web at www.dcboebenefits.com
You may contact me for more information on the products listed:

George E Daniel Jr
Danielhealth
119 Donalson Street
Bainbridge, Georgia 39817
Phone & Fax 229-246-3342 / Cell 229-416-7030
e-mail: dan@danielhealth.com

George E Daniel Jr CIC, CPIA

SYMETRA

George E Daniel Jr CIC, CPIA

119 N Donalson Street
Bainbridge Georgia 39817

Phone 229-246-3342
Fax 229-416-4999
Cell 229-416-7030
e-mail dan@danielhealth.com
Web www.danielhealth.com

New Employees
Decatur County Board of Education
100 N West Street
Bainbridge, Georgia 39817

RE: New Employee Orientation

Welcome!

Congratulations on being a New Employee for the Board of Education! The Board offers some important Employee Benefits that you should consider adding at this time as a new employee. The Benefits are needed and affordable! All benefits will be payroll deducted, and many are pre-taxed.

Many of the coverage's are available now as a new employee without (Underwriting) You should consider these now, as they may not be available later, based on your health. You may apply for coverage or change during open enrollment each year, but in most situations, underwriting will apply, and coverage may be not provided based on your health.

Included in this package of Employee Benefits are the following Benefits, Summaries & Applications.

Group Term Life
Accidental Death & Dismemberment
Whole Life - Permanent Life Insurance
Short Term Disability
Long Term Disability
Dental Reimbursement
Vision Insurance

If you have any additional suggestions or comments, please contact me at 229-246-3342, or e-mail me at dan@danielhealth.com & my Cell is 229-416-7030. You may find additional information on the web at www.dcboebenefits.com

Sincerely,

George E Daniel Jr CIC, CPIA
Certified Insurance Counselor

NEW EMPLOYEE
ORIENTATION
INSURANCE BENEFITS PACKAGE

YOU MAY ENROLL IN OUR EMPLOYEE BENEFITS PROGRAM FOR THE DECATUR COUNTY BOARD OF EDUCATION NOW AS A NEW EMPLOYEE. MANY OF THESE BENEFITS ARE GUARANTEED ISSUE, REGARDLESS OF YOUR PAST MEDICAL CONDITION. HOWEVER, ONCE YOU PASS THIS TIME, THEN INSURANCE BENEFITS MAY BE OFFERED DURING OPEN ENROLLMENT, BUT MAY BE UNDERWRITTEN BASED ON YOUR MEDICAL CONDITION AND YOU MAY BE DENIED COVERAGE

IN THIS PACKAGE

GROUP TERM LIFE
AD&D INSURANCE
UNIVERSAL LIFE

DENTAL REIMBURSEMENT
AVESIS VISION

SHORT TERM DISABILITY
LONG TERM DISABILITY

SEE WWW.DCBOEBENEFITS.COM FOR MORE INFORMATION

AGENT
GEORGE E DANIEL JR CIC, CPIA
Danielhealth
119 Donalson Street
Bainbridge, Georgia 39817
229-416-7030 CELL / 229-246-3342 Work

Employee Benefits – Visit: www.dcboebenefits.com or www.mydcboebenefits.com

Forms & Applications are available on this web address under forms - Open Enrollment Forms
Contact me at Phone: (229) 246-3342 & (229)-416-7030 Cell e-mail: georgeedanieljr@gmail.com

Group Term Life Insurance

You may apply for new coverage or change your current coverage. You may increase your coverage by $10,000 guaranteed Issue, up to a Max Amount of $150,000 each year. You may also increase your spouse if covered by $10,000 a year up to the same amount as the employee. If you change the amount over the $10,000, an evidence of insurability form will be needed on each insured. Children may be added for $15,000 for $3.00. Please complete a new application for all changes. The new app will take president over the older one. Term Life Insurance is Mortality Insurance, Inexpensive, Now Portable to Age 70. Please consider purchasing Universal Life Insurance for longer Life Insurance Needs.

Accidental Death & Dismemberment Insurance (AD&D)

AD&D Insurance is guaranteed Issue on the Employee up to $500,000, and you may purchase up to 50% Coverage on your Spouse of what you carry as the employee. Premiums are inexpensive at .03 per thousand ex: $100,000 = $3.00 Month Please complete an application for changes or new coverage.

Whole Life Insurance

Whole Life Insurance is permanent, Builds Cash Value, You can keep this policy at your current age and rates are for life. You may purchase $10,000; $25,000 ; $50,000; $75,000 or $100,000 guaranteed issue up to Age 55, then simplified issue after that age. Please complete a new application for each member to be insured, Employee, Spouse & Children. A child Term Rider is available, Please ask. You can keep this policy at group rates after you leave the school system.

Short Term Disability

Coverage starts for Disability on the 1st Day in the Hospital Confinement and also for an accident, 7 days for a sickness. Coverage is up to 6 months. Maternity is covered, and coverage applies for a full 12 months if you are in school or not, Includes Summer and Holidays. You may increase coverage each open enrollment . See chart with application for salary, benefits and premiums. Complete a new application to make any changes. Coverage is guaranteed up to $2,166.66. Please complete an EOI if your coverage is above this amount.

Long Term Disability

Coverage starts with a 6 month waiting period and will provide coverage up to Age 65 or longer if still working at age 65. Coverage Benefit is based on 66 2/3 of your gross salary. Premiums are inexpensive and based on salary. Once you have the benefit it tracks with your income, no other changes are needed. Complete the Card LTD Application and EOI for coverage.

(Continue on Back)

Dental Reimbursement

Reimbursement will be made up to $750.00 a person per contract period. Benefits are paid at 100% of the 1st $150.00, then 50% of the next $1,200.00. Premiums are $10.00 for single coverage and $30.00 for family coverage. Please complete a new application for any changes or new applicants. Benefits are paid weekly, Children need proof of school after age 19 to continue to be covered.

Vision Insurance

Avesis offers members discounted Eye Exams at $10.00, then glasses and contacts are discounted to the employee up to $200.00 per member. Other benefits are also available at an Avesis Network Eye Center. Dr Aldridge's Office & Walmart are local Eye Care Avesis Members. Coverage is inexpensive at $5.95 for single employee, $10.38 for Emp + 1 & $15.28 for family coverage. See the application and brochure for more details.

Sample Rates

Group Term Life Rates

$50,000	$ 8.00
$100,000	$16.00
$150,000	$24.00

Children

$15,000	$ 3.00

AD&D Rates

$100,000	$3.00
$300,000	$9.00
$500,000	$15.00

Spouse

$ 50,000	$ 1.50
$150,000	$ 4.50
$250,000	$ 7.50

Whole Life
Age 35

$10,000	$ 13.26
$25,000	$ 24.17
$50,000	$ 45.42

Age 45

$ 10,000	$ 18.91
$ 25,000	$ 36.86
$ 50,000	$ 70.79

Dental

Single $ 10.00
Family $30.00

LTD
Salary Based

$ 10,000	$ 3.33
$ 30,000	$ 9.99
$ 50,000	$16.66

Vision

Single	$ 6.41
Single + 1	$ 11.17
Family	$ 16.45

Short Term Disability

$650.00	$13.35
$1,300	$26.70
$2,166	$44.50
$2,600	$53.40
$3,250	$66.75

GROUP TERM LIFE

You may enroll in Group Term Life Insurance Employees – Guaranteed Issue up to $150,000 or up to 7 Times Salary Maximum

Premium is .16 per $1,000 of Benefit

Examples
$50,000 = $8.00 Pre-Taxed
$100,000 = $16.00
$150,000 = $24.00

Premium for your Spouse is the same as Employee Guarantee on Spouse is $50,000, but can apply for more on a Simplified Basis!

Children up to Age 26 may get $15,000 for $3.00 a month (All Legal Children)

Complete Application
Agent
George E Daniel Jr CIC, CPIA
229-416-7030 Cell / 229-246-3342 Office

* AD&D is also available under separate application *

Plan Highlights

Voluntary Group Term Life Insurance

Decatur County School System

ELIGIBILITY

Any active, full-time employee who works 20 or more hours per week is eligible for this group life insurance plan. There are no medical questions to answer.

Dependents: You must be insured for your spouse to be covered. Your spouse is:

- Your legal spouse not legally separated or divorced from you, or your Civil Union Partner

You must be insured in order for dependent children to be covered. Dependent children are:

- Unmarried financially dependent children*
  *natural and adopted children; stepchildren and foster children in your custody.
  Upper age limits do not apply to handicapped children
- A person may not have coverage as both an Employee and Dependent
- Only one insured spouse may cover Dependent Children

BENEFIT AMOUNT

Voluntary Life

Choose from a minimum of $10,000 to a maximum of $500,000 in $10,000 increments. Guaranteed issue amount is $150,000. Any amounts over the guaranteed issue amount require evidence of insurability.

Dependent Life

Spouse or Civil Union Partner - $50,000

Dependent Child(ren) - $15,000

Additional Spouse Coverage

Coverage from a minimum of $10,000 to a maximum of $150,000 in $10,000 increments. Guaranteed issue amount is $50,000*. Any amounts over the guaranteed issue amount require evidence of insurability.

Spouse coverage terminates at age 75

**Guaranteed Issue only applies to spouses under age 60*

CONTRIBUTION REQUIREMENTS

Employee: Coverage is 100% employee paid

Spouse: Coverage is 100% employee paid

Dependent Child(ren): Coverage is 100% employee paid

BENEFIT REDUCTION DUE TO AGE

AGE	Original Benefit Reduced To
75	60%
80	35%
85	27.5%
90	20%
95	7.5%
100	5%

FEATURES

- Accelerated Death Benefit (expressed as Living Benefit Rider in some states and Imminent Death Benefit in PA)
- Conversion Privilege
- Waiver of Premium
- Portability

EXCLUSIONS

For a comprehensive list of exclusions and limitations, please refer to the Certificate of Insurance. The Certificate also provides all requirements necessary to be eligible for coverage and benefits.

EMPLOYEE AND SPOUSE MONTHLY PREMIUMS

Benefit Amount	Premium
$10,000	$1.60
$20,000	$3.20
$30,000	$4.80
$40,000	$6.40
$50,000	$8.00
$60,000	$9.60
$70,000	$11.20
$80,000	$12.80

Benefit Amount	Premium
$90,000	$14.40
$100,000	$16.00
$110,000	$17.60
$120,000	$19.20
$130,000	$20.80
$140,000	$22.40
$150,000	$24.00

This Plan Highlights is a brief description of the key features of the RSL insurance plan. The availability of the benefits and features described may vary by state. It is not a certificate of insurance or evidence of coverage. Insurance is provided under group policy form LRS-6422.et al.

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

PAL
Plan Administration, Ltd.

RELIANCE STANDARD
Life Insurance Company
a RSLIC company

Administered by:
Plan Administration, Ltd.
580 Hazard Avenue
Enfield, CT 06082
Phone 860-272-1135

Instructions: Type or print with ballpoint pen.

Group Insurance Enrollment Form

Policyholder/Employer Educational School System DECATUR COUNTY BOARD OF EDUCATION				Pal # 560
Full-Time Employment Date		Location/Bill Group		Class
Hours Per Week	Job Title	Base Salary	Gender	Employee SS #:
Employee's Full Name Last First				Employee's Birth Date
Spouse's Full Name Last First				Spouse's Birth Date

Voluntary Life Coverage
Benefit Amount: from $10,000 to $150,000 in increments of $10,000

Employee Coverage	Spouse Coverage	Benefit Amount	Premium
❑	❑	$10,000	$1.60
❑	❑	$20,000	$3.20
❑	❑	$30,000	$4.80
❑	❑	$40,000	$6.40
❑	❑	$50,000	$8.00
❑	❑*	$60,000	$9.60
❑	❑*	$70,000	$11.20
❑	❑*	$80,000	$12.80

Employee Coverage	Spouse Coverage	Benefit Amount	Premium
❑	❑*	$90,000	$14.40
❑	❑*	$100,000	$16.00
❑	❑*	$110,000	$17.60
❑	❑*	$120,000	$19.20
❑	❑*	$130,000	$20.80
❑	❑*	$140,000	$22.40
❑	❑*	$150,000	$24.00

❑ Decline Employee Coverage ❑ Decline Spouse Coverage

Dependent Voluntary Life Coverage
❑ Benefit Amount: Child(ren)
$15,000 for $3.00
❑ Decline Coverage

Employee Amount $ _____

Spouse Amount $ _____

Write In Amounts over $150,000

Premiums listed are for an employee or spouse. For example, if you elect $10,000 for both yourself and your spouse, the premium is $3.20 ($1.60 + $1.60).

BENEFICIARY DESIGNATIONS

	Last Name	First	Initial	Relationship	% of Proceeds
Employee					
	Last Name	First	Initial	Relationship	% of Proceeds
Spouse					

I authorize my employer to deduct from my salary or wages the necessary premium for the coverage requested above. The signature below also verifies the accuracy of the information contained on this form.

Declination of Group Insurance Coverage
❑ I have been offered and have declined to purchase Group Insurance Coverage(s) as noted above. I understand that in the event I desire such insurance at a later date: (1) I will be required to furnish evidence of insurability at my own expense; and (2) Reliance Standard Life Insurance Company (RSL) will have the right to refuse my request.

I understand that any coverage will not become effective until and unless approved by RSL, and upon approval, any benefits payable are subject to the terms, conditions and limitations of the Group Supplemental Life and Disability Policy/ies. I also understand that the amount of any payroll deduction may be adjusted based on underwriting changes or age changes that affect the rates charged.

X _____ _____
Employee Signature Date

Please sign, date and return enrollment form to Plan Administration, Ltd. upon completion.
All amounts in excess of $50,000 for your spouse or if spouse is over age 60 will require a completed insurability form be submitted.
To obtain a form, please call 1-860-272-1135, and one will be sent to you.

Reliance Standard Life Insurance Company
Enrollment and Statement of Health

Name of Employer **Decatur County Board of Education**			Location/Division	
Policy # and Class #	Policy # and Class #	Policy # and Class #	Policy # and Class #	Bill Group 000001

Application Type: ☐ Initial Eligibility/New Hire ☐ Late Applicant ☐ Other _____

☐ Increase ☐ Approved Annual Enrollment

☐ Change in Status: Nature of Change(s): _____

Date of Change: _____

If marriage, divorce or birth of a child, please provide copy of document.

Employee/Member Information – Always Complete

Submit completed Enrollment and Statement of Health form to:

Plan Administration LTD
580 Hazard Avenue
Enfield, CT 06082

We do not accept faxed forms.

Name				Social Security Number	
Gender	Date of Birth	Age	State of Birth		Date of Hire
Address			City	State	Zip
Phone Number	Occupation		Annual Compensation	Hours Worked Per Week	
Email Address					

Are you actively performing all the duties of your occupation or profession? ☐ Yes ☐ No

If "No," explain: _____

Spouse Information – Complete Only If Applying for Spouse Coverage

Spouse Name	Gender	Date of Birth	Age	State of Birth
Address	City	State		Zip

Coverage Elected and Amounts

Coverage	Enroll or Decline[1]	Current Amount	Increase or Decrease	Total Amount Applied For	Weekly Premium
Voluntary Term Life: Employee[2]	☐ Enroll ☐ Decline		+$_____ -$	☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000 ☐ Other_____	See Premium Table
Voluntary Term Life: Spouse[2]	☐ Enroll ☐ Decline		+$_____ -$_____	$_____	See Premium Table
Voluntary Term Life: Dep Children (Coverage subject to election of employee or spouse Term Life)	☐ Enroll ☐ Decline		To: ☐ $5,000 ☐ $10,000	☐ $5,000 ☐ $10,000	See Premium Table

[1]"Enroll" authorizes employer to payroll deduct premiums.
[2]Statement of Health may be required.

Clients using Online Billing and Enrollment: Dependent child coverage requires one dependent child record including first name, last name and date of birth. If multiple dependent children are covered, only 1 dependent child record is required. If you do not have the dependent child's information, enter the First Name as "Child" and use the employee's Last Name and employee's Date of Birth to add dependent child coverage.

Employee/Member Name	Date of Birth

Health Questions

Answer all questions on this page for each person being underwritten for insurance. For any "Yes" answer, underline the condition and record details in the space provided on the next page. Failure to provide details of a condition will cause a delay in the review of your application.

	EMPLOYEE	SPOUSE
Enter height and weight.	Ht. __ft. ___in. Wt. _____ lbs	Ht. __ft. ___in. Wt. _____ lbs
1. In the past 10 years, have you or your spouse been treated for or diagnosed as having: heart, liver (biliary cirrhosis) or kidney disorder; an abnormal colonoscopy requiring follow-up; neurological disorder; diabetes; high blood pressure; thyroid disorder; stroke; transient ischemic attack (TIA); cancer and/or tumor malignant or benign; mental or nervous disorder; or been advised to have treatment for drug abuse (illegal or prescription drugs) or alcoholism?	☐ Yes ☐ No	☐ Yes ☐ No
2. In the past 10 years, have you or your spouse been diagnosed with or treated for: chronic pain; arthritis (lupus, rheumatoid or osteoarthritis); musculoskeletal (back, neck or muscle) condition; respiratory disorder including asthma, chronic obstructive pulmonary disease (COPD); or emphysema?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you or your spouse: (a) in the past year had: fever persisting more than one month; significant involuntary weight loss; diarrhea persisting more than one month; oral candidiasis (thrush); or lymphadenopathy (enlarged or swollen glands)? or (b) in the past 10 years ever tested positive or been treated for HIV (Human Immunodeficiency Virus) antibodies, AIDS or AIDS-related complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No
4 In the past 10 years, have you or your spouse: (a) consulted with or been examined or treated by a physician, practitioner or specialist (include routine physicals only when there is an existing or newly diagnosed medical condition)? (b) been in a hospital or other facility for observation, diagnosis, treatment or an operation? or (c) been prescribed medication(s) (other than for colds, flu or allergies)?	☐ Yes ☐ No	☐ Yes ☐ No
5. Are you currently pregnant? In the past 10 years, have you or your spouse been diagnosed with: abnormal uterine bleeding; abnormal pap smear; abnormal mammogram requiring additional studies or with recommendation of breast biopsy?	☐ Yes ☐ No	☐ Yes ☐ No

Employee/Member Primary Care Physician's Full Name	Office Phone Number
Address	
Spouse Primary Care Physician's Full Name	Office Phone Number
Address	

Employee/Member Name	Date of Birth

Details

Please provide all names used for medical records (if different than the names provided on this form):_____

_____

For each "Yes" response to a health question, please provide details below.

Question #	Illness or Nature of Injury	Date	Physician's Full Name and Address (if different than Primary)	Check One Employee or Spouse	

If you need more space, check here ☐. Complete, sign and date a separate sheet of paper and attach it to this page.

Read, Sign and Date Below

I understand and agree that:

- The information provided on this Enrollment and Statement of Health form is true and correct to the best of my knowledge.
- The insurance requested will become effective in accordance with the individual effective date information in the Policy; any amount subject to evidence of insurability will not become effective until approved by Reliance Standard and Reliance Standard has the right to refuse my request. Coverage is subject to a minimum participation requirement at the employer level and if the minimum is not met, coverage may not be issued even though an enrollment form has been completed. An effective date is subject to eligibility requirements, satisfaction of service waiting period (if applicable) and payment of first premium when due. An effective date may be deferred for an employee not actively at work and enrolled dependents confined to a hospital or at home.
- Benefits are subject to terms and conditions of the Policy.
- For age-banded rate plans, premiums increase as an employee (or spouse, if applicable) moves from one age band to the next.
- If payroll deduction of premiums begins prior to Reliance Standard's processing of the enrollment form, it does not mean coverage is in effect; premiums paid for coverage not issued will be returned.

I further understand and agree that if I am applying after the expiration of my initial eligibility period, all medical tests and costs for attending physician reports may be without expense to Reliance Standard Life Insurance Company and I may be responsible for paying the expenses, if any.

I acknowledge receipt of the "Designation of Beneficiary" form and "Important Information Regarding Applications for Insurance" and "Notice Regarding Information Practices". If a Designation of Beneficiary form is not completed or one is not on file with the Plan Administrator, the provisions of the Policy will determine to whom benefits, if any, will be payable.

AUTHORIZATION: I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, organization, institution, person or the MIB, Inc. to release any information or record(s) on me or my health to be used in determining the acceptability of my application for insurance. I authorize any such information or record(s) to be released to Reliance Standard Life Insurance Company, its reinsurers or authorized representatives. I also authorize Reliance Standard or its reinsurers to make a brief report of my personal health information to the MIB. This authorization, or a photographic copy, shall be as binding as the original and valid for a period not exceeding twelve (12) months from this date. I understand that I (or my authorized representative) will be sent a copy of this Authorization upon request.

Please Note: During an approved enrollment, guaranteed issue amounts of insurance will not require a Statement of Health form provided the Enrollment form is complete, signed and received by your employer during your enrollment period and: a) you are not a late applicant with respect to insurance for yourself (and/or your spouse, if applicable); or b) during your present service with your employer or an affiliate, you (and/or your spouse, if applicable,) have not, with respect to insurance with Reliance Standard or an affiliate: had an application withdrawn; been previously declined; had coverage postponed; or voluntarily terminated; or c) the enrollment period is not one with specific guaranteed issue/health acceptability rules.

X _____	_____	X _____	_____
Employee's/Member's Signature (required at all times)	Date	Spouse's Signature (required if spouse Statement of Health required)	Date

RELIANCE STANDARD
LIFE INSURANCE COMPANY
A MEMBER OF THE TOKIO MARINE GROUP

Designation of Beneficiary

Policyholder **DECATUR COUNTY BOE**	Policy Number(s)
Insured Name	Social Security Number

I hereby designate the following as my beneficiary (ies) under the above policy number(s):
Primary Beneficiary(ies)

Full Name and Address (Please Print)	Percentage* (Must total 100%)	Date of Birth	Relationship	Social Security Number

* If no percentages are indicated, benefits will be divided equally between all primary beneficiaries.

Contingent Beneficiary(ies) (applicable only if you are not survived by one or more primary beneficiaries)

Full Name and Address (Please Print)	Percentage* (Must total 100%)	Date of Birth	Relationship	Social Security Number

* If no percentages are indicated, any benefits payable to contingent beneficiaries will be divided equally between all contingent beneficiaries.

- This beneficiary designation revokes all revocable prior beneficiary designations.
- Unless you indicate otherwise, if any beneficiary predeceases you, that beneficiary's share will be divided pro-rata among the surviving beneficiaries of the same class (primary or contingent).
- If no beneficiary (primary or contingent) survives you, payment will be made pursuant to the terms of the applicable policy.

Date	Signature of Insured

AD&D

ACCIDENTAL DEATH & DISMEMBERMENT

You may enroll in the New AD&D Insurance Now!
Employees – Guaranteed Issue up to $500,000
Spouse may purchase up to 50% of Employee
Premium is .03 per $1,000 of Benefit

Examples

Employee	Spouse
$ 100,000 = $3.00	$ 50,000 = $1.50
$ 200,000 = $6.00	$ 100,000 = $3.00
$ 300,000 = $9.00	$ 150,000 = $4.50
$ 400,000 = $12.00	$ 200,000 = $6.00
$ 500,000 = $15.00	$ 250,000 = $7.50

Complete Application Attached

George E Daniel Jr CIC, CPIA

229-416-7030 Cell / 229-246-3342 Office

Buy-Up AD&D Enrollment Application

Return To: Plan Administrators, Ltd
580 Hazard Avenue
Enfield, CT 06082

Please print or type all information. Complete and sign at the bottom.

EMPLOYEE Name LAST	FIRST	MIDDLE INITIAL	Social Security No	Group Number	Division	Class
Home Address City	State	ZIP	Sex MALE FEMALE	Date of Birth		Marital Status
Your Occupation	Employer Name Decatur County Board of Educaton		Hire Date	Hours worked per week		Annual Salary
Primary Beneficiary (For Employee Life)		Social Security #	Relationship			Date of Birth
Contingent Beneficiary		Social Security #	Relationship			Date of Birth

Life Coverage Requested:

Check Employee Coverage Desired

Coverage Amount	Monthly Rates
$100,000	$3.00
$200,000	$6.00
$300,000	$9.00
$400,000	$12.00
$500,000	$15.00

Check Spouse Coverage Desired

$50,000	$1.50
$100,000	$3.00
$150,000	$4.50
$200,000	$6.00
$250,000	$7.50

If applying for Spouse Coverage, complete section below.

	Name (Last, First, MI)	Social Security #	Date of Birth	Sex (M/F)
Spouse				

AD&D coverage can not exceed $500,000 in total including that currently in force.
Spouse coverage can not exceed 50% of employee amount.

Spouse Beneficiary:

To decline coverage, complete this section. ☐ **Employee** ☐ **Spouse/Dependent**

I understand that I have been given an opportunity to participate in the group insurance plan offered by my employer I am refusing the term life insurance coverage indicated above for which I am required to contribute. If I and/or my dependents wish to participate at a later date, I understand that coverage(s) may be limited and satisfactory evidence of insurability may be required.

Reason for refusing coverage: _____

Employee's signature: _____ Date: _____

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under group policy(ies) issued to the employer listed above. I understand that if I am not actively at work as defined in the policy on the date my coverage would otherwise become effective, my insurance will not begin until the day I meet the policy definition actively at work.

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 may subject such person to criminal or civil penalties.

Employee's signature: X Date:

Administration
George E Daniel Jr

WHOLE LIFE
Sensible Benefits

You may enroll in Permanent Life Now!
Employees - Guaranteed Issue to $100,000
Simplified Issue

Insured & or Spouse
$10,000 / $25,000 / $50,000 / $75,000 / $100,000
Keep Life Insurance after you Retire!
Premiums based on Age & Amount
Build Cash Value!

Permanent Life Coverage

AD&D & WAIVER OF PREMIUM AVAILABLE

See www.dcboebenefits.com for more information

Complete Application Attached

Agent
George E DanielJr CIC, CPIA
229-416-7030 Cell/ 229-246-3342 Office

Monthly Premiums for Sensible Benefits Whole Life

To determine semi-monthly rates, divide rate in half.

Note: actual premiums may vary due to rounding

NON-SMOKER

Age	$5,000	$10,000	$15,000	$20,000
18	5.55	8.18	10.81	13.44
19	5.67	8.41	11.16	13.90
20	5.78	8.64	11.51	14.37
21	5.89	8.86	11.83	14.80
22	6.00	9.09	12.17	15.25
23	6.12	9.32	12.52	15.72
24	6.23	9.54	12.86	16.17
25	6.35	9.79	13.22	16.65
26	6.49	10.06	13.63	17.20
27	6.63	10.34	14.06	17.77
28	6.78	10.64	14.49	18.35
29	6.93	10.94	14.96	18.97
30	7.09	11.27	15.44	19.62
31	7.28	11.64	15.99	20.35
32	7.47	12.02	16.57	21.12
33	7.68	12.44	17.19	21.95
34	7.88	12.84	17.79	22.75
35	8.09	13.26	18.43	23.60
36	8.31	13.69	19.08	24.47
37	8.53	14.14	19.74	25.35
38	8.77	14.62	20.47	26.32
39	9.02	15.11	21.21	27.30
40	9.28	15.64	21.99	28.35
41	9.57	16.21	22.86	29.50
42	9.87	16.83	23.78	30.74
43	10.20	17.49	24.77	32.05
44	10.55	18.18	25.81	33.44
45	10.92	18.91	26.91	34.90
46	11.32	19.72	28.12	36.52
47	11.75	20.58	29.41	38.24
48	12.20	21.48	30.76	40.04
49	12.67	22.41	32.16	41.90
50	13.15	23.38	33.61	43.84
51	13.55	24.19	34.82	45.45
52	13.98	25.04	36.09	47.15
53	14.43	25.94	37.44	48.95
54	14.92	26.92	38.92	50.92
55	15.45	27.98	40.51	53.04
56	16.04	29.17	42.29	55.42
57	16.67	30.43	44.18	57.94
58	17.34	31.77	46.19	60.62
59	18.03	33.14	48.24	63.35
60	18.72	34.53	50.33	66.14
61	19.54	36.15	52.77	69.39
62	20.37	37.83	55.28	72.74
63	21.26	39.60	57.94	76.29
64	22.20	41.48	60.76	80.04
65	23.22	43.51	63.81	84.10
66	24.19	45.47	66.74	88.02
67	25.24	47.55	69.87	92.19
68	26.35	49.78	73.21	96.64
69	27.52	52.12	76.72	101.32
70	28.76	54.59	80.43	106.27

NON-SMOKER

Age	$25,000	$50,000	$75,000	$100,000
18	13.00	23.09	33.17	43.25
19	13.42	23.92	34.42	44.92
20	13.86	24.79	35.73	46.67
21	14.38	25.84	37.29	48.75
22	14.88	26.84	38.79	50.75
23	15.42	27.92	40.42	52.92
24	16.00	29.09	42.17	55.25
25	16.59	30.25	43.92	57.59
26	17.17	31.42	45.67	59.92
27	17.77	32.63	47.48	62.34
28	18.40	33.88	49.36	64.84
29	19.09	35.25	51.42	67.59
30	19.79	36.67	53.54	70.42
31	20.61	38.29	55.98	73.67
32	21.42	39.92	58.42	76.92
33	22.36	41.79	61.23	80.67
34	23.25	43.59	63.92	84.25
35	24.17	45.42	66.67	87.92
36	25.13	47.34	69.54	91.75
37	26.15	49.38	72.61	95.84
38	27.23	51.54	75.86	100.17
39	28.36	53.79	79.23	104.67
40	29.59	56.25	82.92	109.59
41	30.86	58.79	86.73	114.67
42	32.21	61.50	90.79	120.09
43	33.65	64.38	95.11	125.84
44	35.21	67.50	99.79	132.09
45	36.86	70.79	104.73	138.67
46	38.65	74.38	110.11	145.84
47	40.50	78.09	115.67	153.25
48	42.48	82.04	121.61	161.17
49	44.54	86.17	127.79	169.42
50	46.69	90.46	134.23	178.00
51	48.63	94.34	140.04	185.75
52	50.65	98.38	146.11	193.84
53	52.84	102.75	152.67	202.59
54	55.25	107.59	159.92	212.25
55	57.84	112.75	167.67	222.59
56	60.75	118.59	176.42	234.25
57	63.82	124.71	185.61	246.50
58	67.07	131.21	195.36	259.50
59	70.42	137.92	205.42	272.92
60	73.82	144.71	215.61	286.50
61	77.77	152.63	227.48	302.34
62	81.90	160.88	239.86	318.84
63	86.25	169.59	252.92	336.25
64	90.88	178.84	266.79	354.75
65	95.88	188.84	281.79	374.75
66	100.86	198.79	296.73	394.67
67	106.15	209.38	312.61	415.84
68	111.79	220.67	329.54	438.42
69	117.82	232.71	347.61	462.50
70	124.15	245.38	366.61	487.83

Application for Individual Life Insurance
Sensible Benefits

Please print using dark ink

Grange
Life Insurance

Grange Life Insurance Company
671 South High Street, PO Box 1218
Columbus, OH 43216-1218
800-399-3797

The full application L-3-55 must be used if the applicant is applying for more than $100,000 in Term Life Insurance or in Whole Life Insurance.

Proposed Effective Date.	Group Name	Group Number
/ /	Decatur County Board of Education	G 3101

Section 1 Billing Group Information* *(to be completed by the agent)*

*This is not a group product	☒ Payroll Deduction (select one below) ☒ Employer Paid ☐ Employee Paid	☐ Individual Billing: EFT is the only option *By providing my account information and my financial institution's name, I authorize Grange Life Insurance Company (Grange) to withdraw funds from my checking or savings account to pay premiums on my life insurance policy. This authorization will remain in effect until Grange has received a written request to terminate this agreement*

Section 2 Employee Information

If US Citizen and Permanent Residence questions are both answered "No", stop and contact underwriting

Name (First MI Last)	Date of Birth	Social Security Number
	/ /	- -

Former Name	Mailing Address

City	State	Zip Code	Actively at Work	Number of Hours/Week
			☐ Yes ☐ No	

Physical Address (if mailing address is a P.O. Box)	City	State	Zip Code

Sex	Marital Status	Occupation	Date of Hire
	☐ Married ☐ Single ☐ Other _____		/ /

Daytime Phone	Evening Phone
☐ Business ☐ Cell ☐ Home ( ) -	☐ Business ☐ Cell ☐ Home ( ) -

Email Address	Have you smoked cigarettes in the last 12 months?
	☐ Yes ☐ No

US Citizen	Permanent Residence Status	Alien Registration #	State of Birth
☐ Yes ☐ No	☐ Yes ☐ No		

Section 3 Insured Information: (if different from Employee) ☐ **Spouse** ☐ **Adult Child** ☐ **Address Same as Above**

If US Citizen and Permanent Residence questions are both answered "No", stop and contact underwriting

Name (First MI Last)	Date of Birth	Social Security Number
	/ /	- -

Former Name	Resident Address

City	State	Zip Code

Sex	Marital Status	Occupation
	☐ Married ☐ Single ☐ Other _____	

Daytime Phone	Evening Phone
☐ Business ☐ Cell ☐ Home ( ) -	☐ Business ☐ Cell ☐ Home ( ) -

Email Address	Have you smoked cigarettes in the last 12 months?
	☐ Yes ☐ No

US Citizen	Permanent Residence Status	Alien Registration #	State of Birth
☐ Yes ☐ No	☐ Yes ☐ No		

The Section 3 is only for a spouse to apply with Employee as Section 2

Application for Individual Life Insurance
Sensible Benefits
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Grange Life Insurance Company
671 South High Street, PO Box 1218
Columbus, OH 43216-1218
800-399-3797

Ages 1-25 Only - Benefit $10,000

Section 4 Dependent Child(ren) - Child Rider

The proposed insured must have an issue age under 18 to qualify

First	Middle	Last	Gender	Date of Birth	Age
			☐ F ☐ M	/ /	
			☐ F ☐ M	/ /	
			☐ F ☐ M	/ /	
			☐ F ☐ M	/ /	
			☐ F ☐ M	/ /	
			☐ F ☐ M	/ /	

Section 5 Owner *(complete only if the owner is not the employee)*

The Employee is the assumed Policyowner

Policyowner (Full Legal Name)		Tax ID/Social Security Number	Relationship
Mailing Address	City	State	Zip Code
Physical Address (if mailing address is P.O. Box)	City	State	Zip Code

Section 6 Beneficiary For Proposed Insured *(use Section 13 if additional space is needed)*

If more than one beneficiary is named, the payments will be made equally to the surviving beneficiaries, unless otherwise stated

Primary Beneficiary: Full Name	Birth Date Or Trust Date	SSN/Tax Id #	Percent	Relationship to Insured
	/ /	- -	%	
	/ /	- -	%	
Contingent Beneficiary: Full Name	Birth Date Or Trust Date	SSN/Tax Id #	Percent	Relationship to Insured
	/ /	- -	%	
	/ /	- -	%	

Section 7 Insurance Information *(use Section 13 if additional space is needed)*

STOP

Be sure to answer all questions. If applicable, check the appropriate box and complete replacement form.

	Yes	No
1. Is there any existing life insurance policy or annuity contract covering the proposed insured?	☐	☐
2. Will the policy applied for replace any existing life insurance or annuity?	☐	☐

If the answer to either question is "Yes", please provide the information below. List all life insurance policies and annuity contracts on the proposed insured (including pending applications and reinstatements)

Insured	Insurer	Policy #	Face Amount	Year Issued

Application for Individual Life Insurance
Sensible Benefits

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Grange Life Insurance Company
671 South High Street, PO Box 1218
Columbus, OH 43216-1218
800-399-3797

Section 8 Products and Riders Selection

Select either Term Life or Whole Life. A separate application is required if you would like to apply for both plans

Select Products and Riders Select Product
If any changes to this section are made at the time of policy issue, a signed amendment will be required.

Term Life Insurance	Whole Life Insurance	Insurance Coverage Riders
Face Amount $ _____	Face Amount $ _____	☐ Child Rider: $10,000
☐ 20 Year Term	Non-Forfeiture Options: Reduced Paid Up is the only option	☐ Accidental Death $ _____
☐ 10 Year Term		Accidental Date Rate: .07916635
		Child Rate $10,000 All Children $4.17

Section 9 Qualification Questions *(Spouses and adult children of the employee must complete this section. If you are the employee, your agent will tell you if this section is required to be completed.)*

All applicants that do not qualify for Guarantee Issue must complete this section

1. Height_____ ft. _____ in. Weight_____ lbs. Weight change in the past year ☐ Gain ☐ Loss ☐ None _____ lbs.

	Yes	No
2. Has the proposed insured been diagnosed by a member of the medical profession as having a terminal illness? (Terminal illness is defined as any illness diagnosed that would reasonably be expected to cause death within twenty-four (24) months.)	☐	☐
3. Has a member of the medical profession diagnosed the proposed insured with, or treated or prescribed medication to the proposed insured for: Alzheimer's / Dementia, Cystic Fibrosis, Sickle Cell Anemia, Lou Gehrig's Disease (ALS), or have they received Dialysis	☐	☐
4. Has the proposed insured ever been diagnosed as having or been treated for AIDS (Acquired) Immune Deficiency Syndrome) or ARC (Aids Related Complex) by a member of the medical profession, or tested positive for HIV antibodies as part of a test conducted for the purpose of obtaining insurance?	☐	☐
5. **In the past 2 years**, has a member of the medical profession diagnosed the proposed insured with, or treated or prescribed medication to the proposed insured for Alcohol or Drug Abuse?	☐	☐
Questions 2 through 5 must be answered "No" in order to qualify for Sensible Benefits.		
6. **In the past 2 years**, has a member of the medical profession diagnosed the proposed insured with, or treated or prescribed medication to the proposed insured for: Angina/Chest Pain, Chronic Kidney Disease, Multiple Sclerosis, Parkinson's Disease, Peripheral Vascular Disease, TIA (mini-strokes), Stroke or Systemic Lupus?	☐	☐
7. **In the past 5 years**, has a member of the medical profession diagnosed the proposed insured with or treated or prescribed medication to the proposed insured for: Aneurysm, Cancer other than basal cell, Cardiomyopathy, Organ transplant, Congestive Heart Failure, Emphysema, Heart Attack, Liver Disease (other than fatty liver), Pulmonary Fibrosis, or amputation due to disease?	☐	☐
8. Has a member of the medical profession **ever** diagnosed the proposed insured with, or treated or prescribed medication to the proposed insured for Vascular Disease, Heart Condition or Kidney Disease, and if so, have they been diagnosed, treated or prescribed medication for Diabetes within the last **5 years**?	☐	☐
If questions 6, 7 or 8 are answered "Yes," please provide details below.		

Details *Use Section 13 if additional space is needed)*

Question Number	Details or Reason	Date	Name, Address and Phone Number of Attending Doctor and Hospital
		/ /	
		/ /	
		/ /	

Please print using dark ink.

Grange Life Insurance Company
671 South High Street, PO Box 1218
Columbus, OH 43216-1218
800-399-3797

Section 10 Agreement and Authorization

I/We authorize any insurance company, employer, physician, medical professional, hospital, medical facility, pharmacy, pharmacy benefit manager, consumer reporting agency, the Medical Information Bureau, or any other person or organization that has any record of information about me/us or my/our minor children who are to be insured, to give to Grange Life Insurance Company, its reinsurers or its authorized representatives, (together, the Company) information about other insurance coverage, employment, age, general character, finances, participation in hazardous activities, medical care or advice about any physical or mental condition including information about drugs and alcoholism, prescription history, medications prescribed, or other information the Company requires to determine insurability, eligibility for benefits, investigate claims, or support the business operations of the Company related thereto. I/We further authorize the sources listed above except the Medical Information Bureau to give such information to a consumer reporting agency acting on behalf of Grange Life Insurance Company. Grange Life Insurance Company may release information obtained by this Authorization to its reinsurers, to the Medical Information Bureau, to other insurers with whom I/we have policies or to whom I/we may apply or submit a claim, to other persons or organizations performing business or legal services in connection with an insurance transaction for me/us, or as may otherwise be lawfully required. **I/We have received a copy of the Notice of Insurance Information Practices and Fair Credit Reporting Act Disclosure Notice.** I/We, or my/our authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for 24 months from the date signed which complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. It is the Company's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization, and that information, once disclosed, may not be protected by Federal rules governing privacy and confidentiality. A photographic copy shall be as valid as the original. I/We understand that a copy of this authorization will be provided, upon request, to me/us or a person authorized on my/our behalf. I/We understand that disclosure of information to the Company may subject the information to redisclosure in accordance with the Company's privacy policy and MIB, Inc. rules. This authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent the Company has taken action in reliance on this authorization. Notice of revocation may be sent, in writing, to Grange Life Insurance Company at the address above.

I understand that my Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, Grange Life Insurance Company may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

FRAUD NOTICE: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

REQUEST FOR OWNER'S TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION: Under penalties of perjury, I as the Owner, certify that the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

I/We represent to Grange Life Insurance Company that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I/We agree that the Company can rely on these statements. I/We agree that this application and/or any medical exam form and any supplemental application or amendment to the application will be the basis for any policy issued on this application or any amendment to the application. Any policy issued on this application will be deemed to be delivered in and governed by the laws of the jurisdiction in which this application was signed.

The **USA PATRIOT Act** requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth and taxpayer identification number allows us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided.

Section 11 Proposed Insured and Owner Signatures

The Other Insured must sign if coverage is more than $50,000.

I (We) represent that all statements and answers made in all parts of this application are full, complete and true to the best of my (our) knowledge and belief. It is agreed that:

(1) All such statements and answers shall be the basis for and a part of any policy issued on this application.

(2) No agent or medical examiner can accept risks or make or change contracts or waive Grange's right or requirements.

(3) Grange Life Insurance Company shall incur no liability unless:

A. This application, including a valid group number, is fully completed, dated and signed;

B. The first premium due is paid in full or either the Payroll Deduction Authorization or the Electronic Funds Authorization is completed while each proposed insured is alive;

C. The insurability of each proposed insured remains as described in this application and in any supplements to the application;

D. A policy is formally approved by us and issued on this application and delivered to and accepted by the Owner.

(4) Acceptance of a policy by the Owner shall constitute ratification of any changes made by Grange under "Additional Information/Home Office Endorsement."

X **Signature of Employee**	/ / Date
Signature of Insured (if other than employee)	/ / Date
Signature of Owner (if other than employee)	Bainbridge, Georgia City and State Signed

Grange Life Insurance Company
671 South High Street, PO Box 1218
Columbus, OH 43216-1218
800-399-3797

Sensible Benefits
Payroll Deduction Authorization

Employee:

Employer: **Decatur County Board of Education**

Group Number: **G3101**

Please select and complete one of the two options provided below:

Option 1: Deduction Authorization

1. I hereby authorize my employer, named above, to deduct from my salary (or wages) the required premium payment as consideration for contracts issued by Grange Life Insurance Company, Columbus, Ohio, as they fall due during the continuance of my employment by said employer or until this authorization is revoked by me.
2. The final amount charged may vary from the amount quoted based on underwriting results or coverage changes you elect.

Amount of Deduction

Employee $
Child Rider $
Spouse $
Other $
Total Amount of Deduction $

Date of Initial Deduction / /

☐ 13thly (paid weekly or bi-weekly)
☐ Monthly (paid semi-monthly or monthly)

/ / X

Date Signed Employee Signature

Option 2: Waiver of Participation

My signature below certifies that I have been made aware of the features and benefits of the plan offered to me as an optional benefit through my employer, and I have decided not to participate at this time. By waiving this benefit, I understand that I will not be eligible for guaranteed issue in the future.

/ /

Date Signed Employee Signature

Grange Life Insurance Company
671 South High Street, PO Box 1218
Columbus, OH 43216-1218
800-399-3797

Section 12 Agent Certification/Report

STOP

Be sure to answer all four questions

	Yes	No
(a) Have you issued the "Notice of Information Practices?"	☐	☐
(b) I have truly and accurately recorded all Proposed Insureds' answers on this application	☐	☐
(c) I have witnessed his/her/their signature(s) hereon. (If "No", provide details in "Additional Information/Home Office Endorsements" Section.)	☐	☐
	Will	**Will Not**
(d) To the best of my knowledge, the insurance applied for will or will not replace any Life Insurance, and/or Annuities	☐	☐

George E Daniel Jr
Agent's Name (print)

Signature of Agent

Bainbridge, Georgia
City and State Signed

10-006
Agent Number

Section 13 Additional Information/Home Office Endorsement

DENTAL REIMBURSEMENT

You may enroll in Dental Reimbursement Now!
Employees – $10.00
Family – $30.00

Pays 100% of the 1st $150.00 then
50% of the next $1,200.00

REIMBURSEMENT FOR DENTAL EXPENSES: the table above shows the reimbursement from Decatur County Board of Education for Dental Expenses. The Benefit Policy Year is from January 1st through December 31th of each year.

Your Dental Reimbursement checks will be processed weekly, picking up on Tuesday and paying by Thursday of each week.

If you have your claim form and receipt in the central office on Monday, your claim check will be processed and paid by Thursday of the same week.

See www.dcboebenefits.net for more information

Complete Application

Agent
George E Daniel Jr CIC, CPIA
229-416-7030 Cell / 229-246-3342 Office

Decatur County Board of Education

Dental Reimbursement Plan Enrollment Election From

Employee Name: _____

Employee SS#: _____/_____/_____ **Employee D/O/B:** _____/_____/_____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home/Cell Phone: _____ **Work Phone:** _____

School/Work Location: _____ **E-Mail:** _____

Please choose the appropriate option below:

Employee/Single Coverage	**Family Coverage**	I choose to NOT enroll in the
$10.00	$30.00	DCBOE Dental Reimbursement
☐	☐	☐

If you elected family coverage, please list dependents below:

Spouse: _____ **D/O/B:** _____/_____/_____ **SS#:** _____/_____/_____

Dependent: _____ **D/O/B:** _____/_____/_____ **SS#:** _____/_____/_____

Dependent: _____ **D/O/B:** _____/_____/_____ **SS#:** _____/_____/_____

Dependent: _____ **D/O/B:** _____/_____/_____ **SS#:** _____/_____/_____

Dependent: _____ **D/O/B:** _____/_____/_____ **SS#:** _____/_____/_____

Dependent: _____ **D/O/B:** _____/_____/_____ **SS#:** _____/_____/_____

HIPPA: This form is used to authorize, the DCBOE, and its agents, or employees, to use or disclose your protected Health Information (PHI) to the administrator, or employee's to administrate our DR Dental Plan. We will use your information for service, billing questions, claims, letters, and to provide your benefits to you. This authorization is at the request of the individual and will expire as of your termination of employment with the DCBOE. You have the right to revoke this authorization at any time by giving written notice of my revocation to the County Office. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation. I have had full opportunity to read and consider the contents of this authorization, and I understand that by signing this form, I am confirming my authorization of the use/or disclosure of my protected health information as described in this form.

Do you have other Dental Insurance? Yes ☐ No ☐

If yes, name of other company: _____

Address: _____

City: _____ State: _____ Zip: _____

Policy Number: _____

I elect or decline coverage offered to me by the DCBOE Dental DR Plan as marked above during open enrollment. I hereby authorize my employer, until this authorization is revoked by written notice, to deduct each month from any earned or accrued wages due me, the amount applicable to the coverage I have selected. I hereby certify that the above information and any attachments thereto are true and correct. I understand misrepresentation or falsification will subject me to penalties and possible legal action

Employee Signature: _____ **Date:** _____/_____/_____

AVESIS – VISION
INSURANCE

You may enroll in Avesis Vision Insurance Now!
Employee = $ 6.41
Employee + 1 = $11.17
Employee & Family = $16.45

$10 Vision Eye Exams
Benefits 12/ 24 Months
In-Network Discounts

Avesis Vision: **See the brochure for Vision for more details**

In Network Benefits - * $200.00 Average retail when choosing frames and lenses package!
LASIK Surgery – Members receive a one-time allowance of $150.00
Contact Lenses – Covered allowance up to $130.00 and follow up exam
$10.00 Eye Exams at Walmart & Bainbridge Ophthalmology, Dr Mike Williams

Progressive Lenses, Discounts on non-covered items, Special Lenses, Pays Out of Network
You must complete a Vision Reimbursement Form for Out-of-Network Claims

See www.dcboebenefits.net for more information

Complete Application
Agent
George E Daniel Jr CIC, CPIA
229-416-7030 Cell / 229-246-3342 Office

YOUR AVESIS VISION PLAN

Decatur County Schools - Bainbridge, Georgia

Your vision health is an important part of complete wellness. Avesis is pleased to present your vision benefits which are designed to give you and your covered family members the care, value and service to help maintain good vision and overall health.

In-Network Benefits

Vision Examination **Your vision exam is covered in full after a co-pay.**

$200* average retail When choosing the **frames** and **spectacle lenses** package!

FRAMES

Providers typically charge between $100 - $150* for frames covered in full by your plan allowance.**

AND

SPECTACLE LENSES

Contact Lenses In lieu of frames and spectacle lenses, members receive an allowance up to $130 for materials and fit and follow-up exam

Medically necessary contact lenses are covered in full (prior authorization is required)

LASIK Surgery Members receive a one-time/lifetime allowance of $150

Group Details

Effective Date:	**01/01/2013**
Group Number:	**30813-08**
Plan #:	**924**

Benefit Frequency

	Every:
Vision Exam	12 Months
Spectacle Lenses	12 Months
Frames	24 Months
Contact Lenses	12 Months

Co-Pays

Vision Examination	$10.00
Materials	$10.00

Rates

Employee Paid Rates Per Month

Employee Only	*$ 6.41*
Employee + One	*$11.17*
Employee + Family	*$16.45*

Additional Discounts

Progressive Lenses
Are discounted up to 20% off retail in addition to a $50 allowance

Lens Options, Non-Covered Items and Additional Purchases
Are discounted up to 20% off retail

Specialty Lenses
Are discounted up to 20% off retail in addition to the corresponding standard lens allowance

LASIK Surgery
5% - 25% off retail

* Values provided may be more or less depending on the providers retail pricing.

** Provider wholesale frame pricing for your plan is $50. Participating Wal Mart locations cover frames up to a $68 retail value.

Out-of-Network Reimbursement

	Up to:
Exam	$35.00
Standard Single Vision	$25.00
Standard Bifocal	$40.00
Standard Trifocal	$50.00
Standard Lenticular	$80.00
Progressive	$40.00
Specialty Lenses	Corresponding Standard Lens Reimbursement
Frame	$45.00
Contact Lenses (Elective)	$130.00
Contact Lenses (Med. Necessary)	$250.00
LASIK Surgery	$150.00

Avēsis

A National Vision and Dental Company

Policy #: VC-16, Form M-9059

www.avesis.com

Avesis

A National Vision and Dental Company

Advantage Vision

Decatur County Schools - Bainbridge, Georgia

VISION CARE PLAN EMPLOYEE ENROLLMENT FORM

☐ Change ☐ Add ☐ Terminate Effective Date _____

Group Number 30813-08 Plan Number 924 Division All

Employer Group Name Decatur County Board of Education - Bainbridge, Georgia

Date of Employment _____ School Location: _____

Employee Name _____ Date of Birth _____
Last First MI

Address _____ City _____ State _____ Zip _____

Social Security Number _____ ☐ Male ☐ Female

Do you wish to cover your eligible Dependents? ☐ Yes ☐ No

If yes, complete the following e-mail _____ Phone _____

	Last / First	MI	Date of Birth		Last First	MI	Date of Birth
Spouse				Child			
Child				Child			
Child				Child			
Child				Child			

I hereby **apply** for coverage under Avesis Third Party Administrators, Inc. for which I am now entitled or may become entitled under the provisions of the plan. I authorize deductions from my earnings of the required contributions towards the cost of the coverage. I certify that I am eligible to participate and that the above information is correct. I agree that once enrolled, I will remain enrolled during the designated plan period.

☐ I hereby **decline** coverage offered to me by the DCBOE Vision Plan as marked during enrollment. I hereby authorize my employer until this authorization is revoked by written notice, to deduct each month from any earned wages due me the amount applicable to the coverage selected.

Date _____ Signature _____

Ed: 062013

SHORT TERM DISABILITY

You may enroll in Short Term Disability Now!
Employees – Guaranteed Issue up to $2,000 a month
0 day Waiting Period for Accidents & Hospital
7 Day Waiting Period for Sickness

Benefits last up to 6 Months!
Increase by $100 a year up to Guaranteed Benefit
Premiums based on the Selected Benefit
(See Chart on Application)

See www.dcboebenefits.net for more information

Complete Application Attached

Agent
George E Daniel Jr CIC, CPIA
229-416-7030 Cell / 229-246-3342 Office

Decatur County Board of Education

SUN LIFE EMPLOYEE BENEFITS

Protect what you love about your life

Sun Life Financial®

Voluntary
Short-Term Disability Insurance*

Decatur County Board of Education | All Eligible Employees | 934231

Protect your paycheck

Imagine you hurt your back, and your doctor recommends you stay home from work for four weeks. Or imagine you just delivered twins. You can't work, but you have bills to pay. Short-term disability replaces part of your income if you can't work for a short time due to a covered disability. You can use the weekly check to help pay everyday expenses, like your mortgage or rent, utilities, childcare and groceries.

How it works

Your employer is offering you and your coworkers this coverage as a group, at a group rate. You are responsible for paying a portion or all of the cost.

Choose the benefit that best meets your needs and your budget.

Benefits

Weekly benefit after your claim is approved	Get a weekly check of **$50** to **$1,150**, in any **$50** increment you choose, to replace a portion of your income—up to **66.67%** of your Total Weekly Earnings-with no medical questions asked up to the Guaranteed Issue amount of **$500** per week.
When benefits begin	Benefits begin as soon as **1 day** from the date you are unable to work due to an injury and **8 days** due to an illness.
Benefits may be paid for	**Up to 26 weeks**, as long as you are still unable to work due to a covered disability.
Additional plan information	You're covered for injury or sickness 24 hours a day, seven days a week.

*"1 in 4 workers will miss up to 3 months of work due to illness, injury or pregnancy during their career."***

Sun Life Financial®

What did Short-Term Disability insurance mean for Joyce?

Joyce was out apple-picking when she fell off the ladder and broke her ankle. Her injury left her unable to work at her job while she had surgery and recovered at home.

- Joyce filed a claim with Sun Life. We reviewed her medical information and job description and approved her claim.
- Joyce started receiving her weekly benefit, which helped her pay rent, buy groceries and cover the co-pays for doctor visits.
- Six weeks later, Joyce was back at work.

Top 5

Short-Term Disability diagnoses:

1. Maternity
2. Musculoskeletal
3. Injury
4. Digestive disorders
5. Cancer

Sun Life claims data, July 2018

Sun Life Assurance Company of Canada
sunlife.com
800-247-6875

Rate Sheet

Employee – Coverage and **Monthly** cost for Short Term Disability.

Rates are effective as of January 1, 2020.

The chart below shows possible coverage amounts and corresponding costs per Monthly pay period.

Locate the annual earnings closest to your salary, without exceeding it. The corresponding coverage amount represents the maximum coverage you could select.

Find your age bracket (as of the effective date of coverage) to determine the associated cost for the coverage amount you choose.

Annual Earnings	Weekly Coverage Amounts	Monthly Coverage Amounts	Age and Cost 99+
$3,900	$50	$216.66	4.45
$7,800	$100	$433.33	8.90
$11,700	$150	$650.00	13.35
$15,600	$200	$866.66	17.80
$19,500	$250	$1,083.33	22.25
$23,399	$300	$1,300.00	26.70
$27,299	$350	$1,516.66	31.15
$31,199	$400	$1,733.33	35.60
$35,099	$450	$1,950.00	40.05
$38,999	$500	$2,166.66	44.50
$42,898	$550	$2,383.33	48.95
$46,798	$600	$2,600.00	53.40
$50,698	$650	$2,816.66	57.85
$54,598	$700	$3,033.33	62.30
$58,498	$750	$3,250.00	66.75
$62,397	$800	$3,466.66	71.20
$66,297	$850	$3,683.33	75.65
$70,197	$900	$3,900.00	80.10
$74,097	$950	$4,116.66	84.55
$77,997	$1,000	$4,333.33	89.00
$81,896	$1,050	$4,550.00	93.45
$85,796	$1,100	$4,766.66	97.90
$89,696	$1,150	$4,983.33	102.35

Sun Life Financial

Group Enrollment form

Sun Life Financial®

☐ Sun Life Assurance Company of Canada
One Sun Life Executive Park
Wellesley Hills, MA 02481

☐ Sun Life and Health Insurance Company (U.S.)
One Sun Life Executive Park
Wellesley Hills, MA 02481

1. General Information

Employer Name	**Account / Policy Number**	**Location**	**Date Effective**
Decatur County Board of Education	934231	Bainbridge, GA	
Street Address	**City**	**State** GA	**Zip Code**
Type of activity: ☐ New Enrollment ☐ Change Reason:		**Occupation**	

2. Employee Information

Employee's Full Legal Name (First, M.I., Last)		☐ Male ☐ Female	**Date of Birth**
Street Address	**City**	**State**	**Zip Code**
Marital Status	**Social Security Number**	**Phone Number**	
Date employed: ☒ Full-Time Date:	☐ Part-Time Date:	☐ Rehire Date:	☐ Return from layoff Date:
Current Active Employment Type 40 # of hours ☒ Full-Time ☐ Part-Time	**Employee Status:** ☐ Management ☒ Salary ☐ Hourly ☐ Union ☐ Non-Union ☐ Retired		**Salary**

You need to complete all sections of the enrollment form including electing or refusing insurance coverage below from one of the insurance companies above, outside of New York, and sign it. This must be done either during the enrollment period or within 31 days of your eligibility date. Benefits completely paid by your employer ("non-contributory benefits") cannot be refused. Not all of the benefit options listed below will be necessarily available to you. Your employer will tell you which benefits are available and what your Maximum Guaranteed Issue amount is. See the Evidence of Insurability section for details.

3. Benefit Elections

Disability Coverage; underwritten by Sun Life Assurance Company of Canada (Wellesley, MA)

Short Term Disability Insurance

Choice 1 ☒ Elect ☐ Refuse

Coverage amount selected _____

4. Evidence of Insurability and authorization information

A medical Evidence of Insurability ("EOI") application will be required for any employee who applies for coverage more than 31 days past his/her eligibility date. An EOI application is also needed if you:

- apply for higher coverage than the maximum Guaranteed Issue amount.
- want to increase your existing coverage now or at a later date, whether your existing coverage is with Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.) or a prior insurance carrier.
- decline coverage and then want it at a later date.

Coverage subject to evidence of insurability will not go into effect until Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.) approves it.

I understand that:

- I am requesting coverage under a Group Insurance policy offered by my employer. This coverage will end when my employment terminates, subject to any portability or continuation provisions available under the Group Insurance policy.
- My employer will deduct all or part of the premium for contributory coverage from my pay.
- If I decline coverage for myself or, if applicable, for my family now and want it at a later date, I/we will have to submit an Evidence of Insurability application which is acceptable to Sun Life Assurance Company of Canada and/or Sun Life and Health Insurance Company (U.S.). I have read the Evidence of Insurability notice.
- If I am not actively at work due to injury, illness, layoff or leave of absence on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date I return to work.
- When required by the coverage, if my spouse or any of my dependent children are confined due to an injury or illness, as required by the coverage, on the date that any initial or increased coverage is scheduled to start under the plan, such coverage will not start until the date they are no longer confined and are able to perform their normal activities.

By signing below, I am representing that the information I have provided is true and correct to the best of my knowledge and belief.

Signature of employee	Date signed
X	

To the Employee: Make a copy of this form for your records before submitting it to your employer.
To the Employer: This original enrollment form should remain at the employer's site. Family status, coverage, or beneficiary changes should be recorded on another copy of the Enrollment Form.

5. Employer Information

For Employer Use Only.
Provide the employee's earnings amount below.

Indicate pay frequency. If hourly, please indicate the number of hours worked per week. Although most plans define earnings as **salary-only** (not including bonuses, commissions, etc.), you should check your group policy for the proper earnings definition to use.

STD Earnings $	☐ Annual ☐ Monthly	☐ Semi-Monthly ☐ Bi-Weekly	☐ Weekly	☐ Hourly Number of hours worked per week: _____

LONG TERM DISABILITY

You may enroll in Long Term Disability Now!
Employees – Guaranteed Issue
Benefits are 67 2/3 % of Gross Salary
6 Month Waiting Period for Accidents & Sickness

Benefits last up to Age 65 & More
Premiums based on Salary
Coverage tracks Salary
Inexpensive Coverage

See www.dcboebenefits.net for more information

Complete Application Attached

Agent
George E Daniel Jr CIC, CPIA
229-416-7030 Cell / 229-246-3342 Office

Example Premiums for Long Term Disability

Your Long Term Disability Coverage is based on Salary, Once you purchase this coverage, you will not need to update it as it will follow your salary at 67 2/3% of Gross Salary with a 6 month waiting period for Accident & Sickness. Coverage will last up to Age 65, and further if you continue to work after age 65

To estimate your monthly deduction for Long Term Disability Coverage, please see below:

ANNUAL SALARY _____ X 66.66 % Divided by 12 = _____

Total _____ X .60 = _____ Move decimal 2 places to left

Total Premium : _____

Example

Annual Salary: $35,000 X 66.66% = 23,331.00 Divided by 12 = $1,944.25 X .60 =

1167.00, move decimal 2 places to the left = $11.67 Month Payroll Deduction

PLAN ADMINISTRATION, LTD GROUP ENROLLMENT CARD	Group Policy No. 0560	Cert No.	Social Security (Cert) No.

APPLICANTS Last Name (Please Print)	First Name	Initial	State	Class	SEX M F
				ALL	

APPLICANTS RESIDENCE	Street Address	City	State	Zip

Name of Employer, Association or Union	Location
Decatur County Board of Education	Bainbridge, Georgia 39817

Salary $ Hrs. Worked	Union Non-Union	Date of Birth Mo. Day Year	Occupation	Title

Date Employed Full Time Mo. Day Year	Date Eligible Mo. Day Year	Life & AD&D
		N/A

Other Spouse Benefits	A&S	LTD	Dependent	Sup/Vol
	N/A	YES	N/A	N/A

BENEFICIARY DESIGNATION (Please Print)	First Name	Initial	Last Name	Relationship

I (1) REQUEST THE GROUP INSURANCE COVERAGE FOR WHICH I AM OR MAY BECOME ELIGIBLE (2) AUTHORIZE DEDUCTIONS FROM MY PAY OR DUES FOR MY SHARE OF THE COST, IF ANY, AND (3) DESIGNATE THE BENEFICIARY NAMED ON THIS CARD TO RECEIVE THE PROCEEDS, IF ANY, PAYABLE IF I DIE.

Date Signed _____ X _____ Applicants Signature

Reliance Standard Insurance Company

Please do not fill in Salary, We will get it from the Board of Education

New Teachers are Guaranteed Issue (Now , not during open enrollment)