Decatur County Board of Education

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

Effective Date:_____ Certificate # _____

Instructions: Type or print with ballpoint pen **Group Insurance Enrollment Form**

Employee's Name		Group Name : Decatur County Board of Education	
Street Address		City and State	Zip Code
Date of Hire	Job Title	Base Salary / Gender	Employee's Birth Date
Spouse's Name/Spouse Date of Birth Last First		Spouse Date of Birth	Employee's Social Security Number
Dependent(s) Name/Date of Birth Last First		Dependent(s) Name/Date of Birth	Dependent(s) Name/Date of Birth

Employee Coverage	Employee Benefit Amount	Monthly Employee 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
❑	$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
❑	$_____*	$_____

Spouse Coverage	Spouse Benefit Amount[1]	Monthly Spouse 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
❑	$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 Spouse Coverage	

Dependent Children	Dependent Benefit Amount	Monthly Dependent Premium
❑	$15,000.00	$3.00
❑	Decline Dependent Coverage	

You should start with $50,000 Minimum
Lower amounts are for rates only

GIO for Employees is $150,000
GIO for Spouse is $50,000

[1] Spouse benefit amount cannot exceed 100% of Employee's elected benefit amount. Spouse over age 60 has zero GI amount
*Indicates amount will require EOI

Phone # _____ e-mail:_____

Beneficiary Designations

	Last Name	First	Initial	Relationship	SSN	% of Proceeds
PRIMARY						
CONTINGEN	Last Name	First	Initial	Relationship	SSN	% of Proceeds

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.

Employee 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 will have the right to refuse my request.

I understand that any coverage will not become effective until and unless approved by Reliance Standard Life Insurance Company, and upon approval, any benefits payable are subject to the terms, conditions and limitations of the Group Voluntary Life Policy. I also understand that the amount of any payroll deduction may be adjusted based on underwriting changes that affect the rates charged.

X _____ _____

Employee Signature Date

Please sign, date and return enrollment form to Plan Administration LTD upon completion.
*If you request coverage in excess of the Guaranteed Issue amt. or if spouse is over age 60 Evidence of Insurability form is required. To obtain a form, please call 1-860-272-1135 and one will be sent.

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

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