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.