



Income Protection Benefits

North American Division of Seventh-day Adventists

Supplemental Life Benefits Enrollment Form

Information About You

Name:	Social Security Number:	
Employer (Conference, School, etc.):	Title:	
Effective Date: 6/1/2010	Date of Birth:	Date of Hire:

Instructions

Please enter all required information clearly so that there will be no question as to your meaning.

- Step 1:** Please enter and/or check your coverage elections and details. You may only elect – and will be covered for – levels of coverage included in your employer's contract.
- Step 2:** Your costs should be calculated based on your age and Salary as of your effective date.
- Step 3:** Please sign, date and return this form to your Human Resource representative by 4/15/10.

Supplemental Life Insurance

You can purchase Supplemental Life Insurance in increments of \$10,000. The maximum amount you can purchase cannot be more than 7 times your annual Salary or \$750,000. If you are currently participating in this coverage and currently have an amount more than or equal to 3 times your Salary or \$250,000, whichever is less, you may increase your coverage by \$10,000 without providing evidence of insurability. Additional coverage amounts will require evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

If you are newly eligible and electing for the first time or are currently enrolled with an amount less than 3 times your Salary or \$250,000, whichever is less, you may elect an amount up to the guaranteed issue amount of the lesser of 3 times your annual Salary or \$250,000 without providing evidence of insurability. Additional coverage amounts will require evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

Salary calculations for figuring guaranteed issue: Your salary plus tuition assistance and other taxable income. (Include parsonage allowance or voluntary pre-tax contributions such as 403b retirement contributions, education IRA's, or section 125 benefits.)

$$\text{\$ } \underline{\hspace{2cm}} \text{ Salary} \times 3 = \text{\$ } \underline{\hspace{2cm}} \text{ Guaranteed Issue Maximum**}$$

Your Guaranteed Issue Maximum should be rounded **down to the next lower \$10,000 if not an even multiple thereof.

	Current Coverage (including GI amount) if applicable	Additional (or new) Coverage Requested	*Total Coverage /Life Benefit amount
Employee Supplemental Life			
Spouse Supplemental Life			
Dependent Child Supplemental Life			

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+
Rate	\$0.55	\$0.55	\$0.61	\$0.67	\$0.92	\$1.39	\$2.26	\$3.91	\$4.19	\$7.33	\$13.05	\$20.77	\$29.51	\$46.42	\$77.57

To calculate your Monthly cost, please use the following formula(s):

$$\frac{\text{Life Benefit Amount}}{\$10,000} = \underline{\hspace{2cm}} \times \frac{\text{Rate Above}}{\text{Rate Above}} = \text{\$ } \underline{\hspace{2cm}} \text{ My Monthly Cost *}$$

I elect to purchase the total amount of \$ _____ in Life coverage.

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**Expertise without equal.
Benefits without burden.™**

Name: _____

Spouse Supplemental Life Insurance

If you elect Supplemental Life Insurance for yourself, you may elect Spouse Supplemental Life Insurance in increments of \$10,000. The maximum amount you can purchase cannot be more than the lesser of \$250,000 or 100% of your elected and approved Supplemental Life Insurance. If you are currently participating in this coverage and currently have an amount more than or equal to \$30,000 you may increase your coverage by \$10,000 without providing evidence of insurability. Additional coverage amounts will require evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

If you are newly eligible and electing for the first time or are currently enrolled with an amount less than \$30,000 you may elect an amount up to the guaranteed issue amount \$30,000 without providing evidence of insurability. Additional coverage amounts will require evidence of insurability that is satisfactory to The Hartford before the excess can become effective.

Costs are based on your Spouse's age.

Age	Under 25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+
Rate	\$0.55	\$0.55	\$0.61	\$0.67	\$0.92	\$1.39	\$2.26	\$3.91	\$4.19	\$7.33	\$13.05	\$20.77	\$29.51	\$46.42	\$77.57

To calculate your Monthly cost, please use the following formula(s):

$$\frac{\text{Life Benefit Amount}}{\$10,000} = \text{_____} \times \text{Rate Above} = \$ \text{My Monthly Cost*}$$

I elect to purchase the total amount of \$_____ in Life coverage for my Spouse.

SPOUSE:

First Name	Last Name	Gender	Date of Birth	Date of Marriage

Child(ren) Supplemental Life Insurance

If you purchase Supplemental Life Insurance for yourself, you may purchase Child(ren) Supplemental Life Insurance for your Dependent Child(ren) between the ages of Live Birth and 19 years (26 years if a full time student) in increments of \$1,000. The maximum amount you can purchase is \$25,000.

Please your election.

I Elect Life in the total amount of and My Benefit Will Be:	My total Monthly Cost for all my Covered Child(ren) Will Be:	I Elect Life in the total amount of and My Benefit Will Be:	My total Monthly Cost for all my Covered Child(ren) Will Be:	I Elect Life in the total amount of and My Benefit Will Be:	My total Monthly Cost for all my Covered Child(ren) Will Be:	I Elect Life in the total amount of and My Benefit Will Be:	My total Monthly Cost for all my Covered Child(ren) Will Be:	I Elect Life in the total amount of and My Benefit Will Be:	My total Monthly Cost for all my Covered Child(ren) Will Be:	I Elect Life in the total amount of and My Benefit Will Be:	My total Monthly Cost for all my Covered Child(ren) Will Be:	I Elect Life in the total amount of and My Benefit Will Be:	My total Monthly Cost for all my Covered Child(ren) Will Be:
<input type="checkbox"/> \$1,000	\$0.19	<input type="checkbox"/> \$6,000	\$1.15	<input type="checkbox"/> \$11,000	\$2.11	<input type="checkbox"/> \$16,000	\$3.07	<input type="checkbox"/> \$21,000	\$4.03	<input type="checkbox"/> \$25,000	\$4.80	<input type="checkbox"/> \$25,000	\$4.80
<input type="checkbox"/> \$2,000	\$0.38	<input type="checkbox"/> \$7,000	\$1.34	<input type="checkbox"/> \$12,000	\$2.30	<input type="checkbox"/> \$17,000	\$3.26	<input type="checkbox"/> \$22,000	\$4.22	<input type="checkbox"/> \$25,000	\$4.80	<input type="checkbox"/> \$25,000	\$4.80
<input type="checkbox"/> \$3,000	\$0.58	<input type="checkbox"/> \$8,000	\$1.54	<input type="checkbox"/> \$13,000	\$2.50	<input type="checkbox"/> \$18,000	\$3.46	<input type="checkbox"/> \$23,000	\$4.42	<input type="checkbox"/> \$25,000	\$4.80	<input type="checkbox"/> \$25,000	\$4.80
<input type="checkbox"/> \$4,000	\$0.77	<input type="checkbox"/> \$9,000	\$1.73	<input type="checkbox"/> \$14,000	\$2.69	<input type="checkbox"/> \$19,000	\$3.65	<input type="checkbox"/> \$24,000	\$4.61	<input type="checkbox"/> \$25,000	\$4.80	<input type="checkbox"/> \$25,000	\$4.80
<input type="checkbox"/> \$5,000	\$0.96	<input type="checkbox"/> \$10,000	\$1.92	<input type="checkbox"/> \$15,000	\$2.88	<input type="checkbox"/> \$20,000	\$3.84	<input type="checkbox"/> \$25,000	\$4.80	<input type="checkbox"/> \$25,000	\$4.80	<input type="checkbox"/> \$25,000	\$4.80

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Name: _____

CHILD(REN):

First Name	Last Name	Date of Birth	Gender

Beneficiary Designation

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plans. **This beneficiary designation will be for ALL group life insurance coverage issued by The Hartford for you, unless specifically named otherwise.** Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. Please provide **all** of the information requested below. If your beneficiary is not related either by blood or by marriage, insert the words, "Not Related" as their stated relationship. If you need assistance, contact your benefits administrator or your own legal advisor.

	Full Name	Address	Social Security #	Relationship	Date of Birth	Percentage
Primary Beneficiary						
Contingent Beneficiary						

The beneficiary for insurance on the lives of your spouse and children will automatically be you, if surviving. Otherwise, the beneficiary will be the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.

Spousal Consent For Community Property States Only: If you live in a community property state – Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Disclaimer: Spousal consent does not apply to ERISA plans.

This will certify that, as spouse of the Employee named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of group life insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Employee's Spouse: _____ Date: _____

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Name: _____

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Life insurance coverage described in the Benefit Highlight Sheets and offered through North American Division of Seventh-day Adventists.

I understand and agree that if I decline coverage now, but later decide to enroll, I will be required to provide evidence of insurability that is satisfactory to The Hartford and be approved for such coverage before it becomes effective. I understand my request for coverage may be denied by The Hartford.

I understand and agree that insurance will go into effect and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to the policyholder (your employer) can fully describe the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

If I have life insurance coverage with The Hartford, I understand and agree that my life insurance benefit is reduced at a specified age stated in the policy.

I authorize my employer to make the appropriate payroll deductions from my earnings.

I understand that no insurance will be valid or in force if I am not eligible in accordance with the terms of the group policy as issued to my employer. I acknowledge and agree that if group participation requirements are not met, this policy will not be implemented and the coverage I have elected will not be in force.

Signed _____ Date _____

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