NEW PALTZ UNITED TEACHERS BENEFIT TRUST FUND
Group Insurance Election Form

Life - Policy - 118668 - 017 **LTD - Policy - 118669 - 017** **STD - Policy - 0132768 - 001**

Name: ______________________________ **7/1/2017**

SSN: ____________________ **Date of Birth:** ____________________

Unit (See below) ____________ **Annual Salary** ____________________

**** Date of Hire for Non-Teachers is when appointed Full-Time** **Date of Hire **:** ____________________

Coverage Effective Date: ____________________

Units

001 - NPUT	004 - Bus Drivers	008 - Building Administration
002 - Managerial & Confidential	005 - Retirees	009 - Facilities & Operations
003 - Educational Support Staff	007 - Secretarial & Clerical	010 - Bus Attendants

Premiums are deducted on a 20 payroll deduction basis (20 paychecks September through June)

IMPORTANT! This form must be returned to your Trust Administrator prior to the end of the enrollment period.
New hire enrollment period: If your form is not signed and dated within 31 days after the coverage effective date of this form, you will automatically be enrolled in the Trust-Funded plan.

Re-enrollment period: If your form is not signed, dated and returned before October of the plan year for which elections are being made, you will remain in the option (s) you had previously, or plan most similar, although your premium may change.

Term Life and AD&D Insurance

Base Life/AD&D - Employee **Premium**

TRUST FUNDED PLAN **$200,000** **Paid by the Trust Fund**

Additional Life - Employee **Premium Paid by Member** **See attached table of premiums**

Option A	$50,000	________
Option B	$100,000	________
Option C	$150,000	________
Option D	$200,000	________

Additional Life Option Chosen ________ **Premium** ________

***New Hire & Annual Re-enrollment - Evidence of Insurability is required for member amounts over $200,000 (Base and Additional combined)**

You are eligible for Additional Life on the first of the month following 30 days of active membership. If you enroll more than 31 days after this date you must complete the evidence of insurability form and be approved by Unum.

Maximum Life coverage allowed is $400,000 (Base and Additional Combined)

Life coverage amounts that are contributory and/or medically underwritten may not be payable if you commit suicide within 24 months of your effective date of coverage. Please consult your employee booklet. See your Plan Administrator or refer to your employee booklets for details about other Life exclusions.

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Spouse (Domestic Partner) Life - Spouse (Domestic Partner) coverage may not exceed 100% of your coverage

		Premium	See attached premium schedule		Premium
Option A	Opt Out	$0.00	**Option F**	$125,000	_________
Option B	$25,000	_________	**Option G**	$150,000	_________
Option C	$50,000	_________	**Option H**	$200,000	_________
Option D	$75,000	_________	**Option I**	$250,000	_________
Option E	$100,000	_________	**Option J**	$300,000	_________

Spouse Life Option Chosen _________ **Premium** _________

***New Hire & Annual Re-enrollment - Evidence of Insurability is required for any amount over $25,000.**
If you previously opted out of spouse coverage evidence o insurability is required for all amounts.

Child Life

		Premium
Option A	Opt Out	$0.00
Option B	$4,000**	_________

****Benefit schedule is as follows: Live Birth - 6 months $1,000. 6 months to age 19 (25 if full time student) $4,000**

Child Life Option Chosen _________ **Premium** _________

*** Re-enrollment - Evidence of Insurability is required if you are electing coverage for your child and you previously opted out.**

Dependent Information - If coverage for dependent is applied for **(May use a separate sheet to include additional dependent).**

Name	Date of Birth	Relation to you	Status
______________________	_________	_________	_________
______________________	_________	_________	_________
______________________	_________	_________	_________

Relation to you: SP = spouse; CH = child; ST = stepchild who lives with you and depends upon your financial support
Status: S = full time student age 19-25; H = handicapped person; N = not applicable

Please indicate the name and expected date of graduation for those dependents who are full time students age 19 and over.

Name: ______________________ Expected Graduation Date: ______________
Name: ______________________ Expected Graduation Date: ______________
Name: ______________________ Expected Graduation Date: ______________

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Beneficiary Information

Name of beneficiary (last name, first, middle initial)	Relation to You	Benefit Percent
______________________	__________	__________
______________________	__________	__________
______________________	__________	__________

If the beneficiary (ies) named above are not living then pay:

______________________	__________	__________
______________________	__________	__________

Long Term Disability **Premium**

***Annual salary is your gross annual salary, <u>including</u> overtime pay and additional assignments (see your New Member Portfolio or the Summary Plan Description for the Annual Salary definition).**

70% of Salary to Max of $3,500 per month **Paid by the Trust**

Short Term Disability (For Non- Teachers Only) **Premium**

***Annual salary is your gross annual salary, <u>including</u> overtime pay and additional assignments (see your New Member Portfolio or the Summary Plan Description for the Annual Salary definition).**

70% of Salary to Max of $ 2,000 per week **Paid by the Trust**

Request for Signature: I understand that by signing and submitting this form to elect coverage, I am making a binding election for my benefits and am authorizing payroll deduction from my earnings. I understand that if I decline any of the above coverage's, I cannot later change my mind during the plan year and elect these coverage's, unless I experience a change in status. If for any reason I fail to complete a new enrollment form each plan year, the elections shown on this form will remain unchanged, although the cost may vary.

______________________________ ______________
Member Signature Date

See your Plan Administrator or refer to your enrollment materials for details about pre-existing condition limitations and/or exclusions. Your disability benefit may be reduced by deductible sources of income and any earnings you have while disabled. Deductible sources of income may include such items as disability income or other amounts you receive or are entitled to receive under: workers compensation or similar occupational benefit laws; state compulsory benefit laws; automobile liability and no fault insurance: legal judgements and settlements; certain retirement plans; salary continuation or sick leave plans; other group or association disability program or insurance: and amounts you or your family receive or are entitled to receive from Social Security or similar governmental programs.

Delayed Effective Date: <u>Employee</u> - Initial insurance, and any increased or additional insurance will be delayed if an employee is not in active employment because of an injury, sickness, leave of absence or temporary lay-off on the date that insurance would otherwise be effective. <u>Dependents</u> - Initial insurance coverage will be delayed if a dependent is totally disabled on the date that insurance would otherwise be effective. Exception - Newborn children are insured from live birth.

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UNUM TERM LIFE AND AD&D INSURANCE

Effective 7/1/17		MONTHLY RATE	ANNUAL RATE	DEDUCTION (20)
TERM LIFE INSURANCE	$ 200,000			
Total Premium		$ 18.00	$ 216.00	$ 10.80
Paid by Trust		$ 18.00	$ 216.00	$ 10.80
Paid by Member		$ -	$ -	$ -
ACCIDENTAL DEATH & DISMEMBERMENT				
Total Premium		$ 4.00	$ 48.00	$ 2.40
Paid by Trust		$ 4.00	$ 48.00	$ 2.40
Paid by Member		$ -	$ -	$ -

SUPPLEMENTAL INSURANCE AT AGE BANDED RATE

MEMBER AGE	MONTHLY RATE	ANNUAL RATE PER $ 50,000
< 25	$ 0.05	$ 30.00
25-29	$ 0.03	$ 18.00
30-34	$ 0.05	$ 30.00
35-39	$ 0.08	$ 48.00
40-44	$ 0.12	$ 72.00
45-49	$ 0.19	$ 114.00
50-54	$ 0.34	$ 204.00
55-59	$ 0.56	$ 336.00
60-64	$ 0.70	$ 420.00
65-69	$ 1.22	$ 732.00
70+	$ 3.25	$ 1,950.00

SPOUSE (DOMESTIC PARTNER) INSURANCE AT AGE BANDED RATES

SPOUSE AGE	MONTHLY RATE	ANNUAL RATE PER $ 25,000
< 25	$ 0.11	$ 33.00
25-29	$ 0.08	$ 24.00
30-34	$ 0.10	$ 30.00
35-39	$ 0.12	$ 36.00
40-44	$ 0.19	$ 57.00
45-49	$ 0.32	$ 96.00
50-54	$ 0.57	$ 171.00
55-59	$ 0.91	$ 273.00
60-64	$ 1.06	$ 318.00
65-69	$ 1.78	$ 534.00
70+	$ 4.81	$ 1,443.00