

# SUPPLEMENTAL LIFE INSURANCE CHANGE REQUEST

Hamilton County, Ohio

**Policy Number: 01-016221-00**

<b>Information About You</b>	Name _____	Date of birth _____
	Employee ID # _____	Department/Department # _____

**Complete this section to change employee's name**

 Change employee's name from \_\_\_\_\_ to \_\_\_\_\_  
 as of date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Complete this section to change beneficiary(ies)**
**This beneficiary change cancels and supersedes previous designations and may be changed upon written request.**
**Primary Beneficiary:** The person or persons you want to receive the life insurance benefit if you die. If more than one primary beneficiary is named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

**Contingent Beneficiary:** The person or persons you want to receive the life insurance benefit if you die and no primary beneficiary is alive on that date. If more than one contingent beneficiary is named, and the specific percentage has not been designated, then each will receive an equal share of the benefit.

	Full name	Address	Date of birth	Relationship	% of benefit
<input type="checkbox"/> Primary					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					
<input type="checkbox"/> Primary <input type="checkbox"/> Contingent					

The beneficiary for life insurance on the lives of your Spouse and Dependent Children will automatically be you, if surviving. Otherwise, the beneficiary will be your estate, subject to policy provision.

**Complete this section to change employee's smoking/tobacco user status**

If you are changing your status from a non-smoker/tobacco free status to a smoker/tobacco user status or from a smoker/ tobacco user status to a non-smoker/tobacco free status, please indicate new status. If you have smoked a cigarette, cigar, used pipe or chewing tobacco, used nicotine or snuff during the last 12 months prior to today's date, check the smoker/tobacco user status box.

 Non-Smoker/Tobacco Free     Smoker/Tobacco User

Effective date of change \_\_\_\_ / \_\_\_\_ / \_\_\_\_      New Bi-weekly deduction \$ \_\_\_\_\_

**Complete this section if you are adding supplemental life coverage for yourself**

You may elect Supplemental Life coverage for yourself in increments of \$10,000, not to exceed the lesser of 5 times your annual salary or \$1,000,000. You will be required to provide evidence of good health that is satisfactory to Symetra before your elected amounts can become effective. Supplemental rates and premiums are based on the Employee's age as of December 31, 2013.

Employee date of birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Have you smoked a cigarette, cigar, used pipe or chewing tobacco, used nicotine or snuff during the 12 months prior to today's date?  Yes  No

If YES, use The Tobacco User cost below; if NO, use the Tobacco Free cost below.

Use the rate chart and calculation line below to determine your Bi-Weekly cost for this coverage.

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Tobacco Free Rate	\$0.138	\$0.171	\$0.240	\$0.291	\$0.443	\$0.794	\$1.311	\$1.740	\$3.378	\$6.240	\$12.568
Tobacco User Rate	\$0.245	\$0.369	\$0.549	\$0.738	\$1.214	\$2.003	\$2.880	\$3.480	\$6.065	\$9.969	\$16.352

$$\text{\$ } \frac{\text{Elected Benefit Amount}}{\text{\$ }10,000} = \text{\$ } \frac{\text{Rate Above}}{\text{\$ }10,000} \times \text{\$ } \frac{\text{Rate Above}}{\text{\$ }10,000} = \text{\$ } \text{Your Bi-Weekly Cost}$$

**Complete this section if you are adding supplemental life coverage for a spouse**

You may elect Supplemental Life coverage for your spouse. Your election may be made in increments of \$5,000 to a maximum of \$250,000 (not to exceed 50% of your Employee Supplemental Life amount). If you elect an amount that exceeds the guaranteed issue amount of \$25,000, your spouse will be required to provide evidence of good health that is satisfactory to Symetra before the excess can become effective.

Spouse	First name	Last name	Gender	Date of marriage	Date of birth

Supplemental Spouse rates and premiums are based on the Spouse's age as of December 31, 2013, not the Employee's age.

Use the rate chart and calculation line below to determine your Bi-Weekly cost for this coverage.

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
Rate	\$0.159	\$0.185	\$0.254	\$0.339	\$0.582	\$0.958	\$1.389	\$2.153	\$4.032	\$7.101	\$13.380

$$\text{\$ } \frac{\text{Elected Benefit Amount}}{\text{\$ }5,000} = \text{\$ } \frac{\text{Rate Above}}{\text{\$ }5,000} \times \text{\$ } \frac{\text{Rate Above}}{\text{\$ }5,000} = \text{\$ } \text{Your Bi-Weekly Cost}$$

Effective date of change \_\_\_\_ / \_\_\_\_ / \_\_\_\_      New Bi-weekly Spouse deduction \$ \_\_\_\_\_

**Complete this section if you are adding supplemental life coverage for a child(ren).**

You may elect Supplemental Life coverage for your Dependent Child(ren) between the ages of Live Birth and 19 years (25 years if a full-time student) in increments of \$2,000 to a maximum of \$10,000 (not to exceed 50% of your employee Supplemental Life amount). Children from Live Birth to 6 months are limited to coverage in the amount of \$2,000.

Child(ren)	First name	Last name	Gender	Relationship	Date of birth

Use the rate chart and calculation line below to determine your Bi-Weekly cost for this coverage.

Child Life Amount	\$2,000	\$4,000	\$6,000	\$8,000	\$10,000
Cost per Child Unit	\$0.092	\$0.184	\$0.276	\$0.368	\$0.460

I elect to **enroll** my Dependent Child(ren) in the Supplemental Life plan for \$ \_\_\_\_\_ at the Bi-Weekly cost of \$ \_\_\_\_\_ .  
 (Note: this cost includes all dependent children.)

Effective date of change \_\_\_\_ / \_\_\_\_ / \_\_\_\_      New Bi-weekly Child deduction \$ \_\_\_\_\_

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**Complete this section if terminating supplemental life coverage for yourself or dependents**

Fill in the chart below for you and/or your dependents in which you are terminating supplemental life insurance coverage.

First name	Last name	Gender	Relationship	Date of birth

Reason for terminating employee and/or dependent coverage \_\_\_\_\_

If terminating dependent child coverage due to age limitation, is the dependent disabled?  Yes  No

Date of Family Status Change \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Effective date of change \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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**Sign below for all changes**

I, the undersigned, an employee of the above-named policyholder, elect the insurance coverage which I selected above and for which I am eligible under the terms of the group policy or policies issued to the policyholder by Symetra Life Insurance Company. I authorize the deduction from my earnings of any contribution I am required to make toward the cost of this insurance.

I hereby waive my right at this time to elect the insurance coverages which I did not select above. I understand that if I do not enroll within 31 days, when first eligible, that I will not be able to obtain coverage in the future without submitting satisfactory evidence of insurability (proof of good health) to Symetra Life Insurance Company for approval. I also understand that Symetra Life Insurance Company will have the right to refuse my request for insurance.

I designate the beneficiary(ies) named on this form to receive any benefits payable in the event of my death. All information submitted by me on this form to the best of my knowledge and belief is true and complete.

\_\_\_\_\_  
Employee signature

\_\_\_\_\_  
Date signed

**PLEASE SIGN AND RETURN THIS FORM TO YOUR PAYROLL OFFICER**