

SUPPLEMENTAL LIFE INSURANCE NEW HIRE ENROLLMENT

Hamilton County, Ohio

Policy Number: 01-016221-00

Information About You	Name			Date of birth
	Employee ID #	Department/Department #	Date of hire	Annual salary
	Home address			
	City	State	Zip Code	

Instructions

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

Step 1: Please enter 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: Please sign, date and return this for your Departmental Payroll Officer.

The following costs should be calculated based on your age as of December 31, 2013.

Supplemental Life Insurance – Employee

You have the opportunity to enroll in Hamilton County, Ohio's Supplemental Life Insurance plan insured by Symetra Life Insurance Company. Your election may be made in increments of \$10,000, not to exceed the lesser of 5 times your salary or \$1,000,000. If you elect an amount that exceeds the guaranteed issue amount of \$100,000, you will be required to provide evidence of good health that is satisfactory to Symetra before the excess can become effective. You must complete the Beneficiary Designation section on page 3 of this application.

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

I elect to **enroll** in the Supplemental Life plan at the Bi-Weekly cost below.

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

I elect to **decline** the Supplemental Life plan.

PLEASE SIGN AND RETURN THIS FORM TO YOUR PAYROLL OFFICER

Employee Name _____
(Please print)

Beneficiary Designation

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					

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. A beneficiary for employee Life Insurance may be changed upon written request.

Selection/Waiver of Group Insurance

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

Payroll Officer Initials _____

PLEASE SIGN AND RETURN THIS FORM TO YOUR PAYROLL OFFICER