

EMPLOYEE INFORMATION			
Employee Name	Date of Birth	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN
Employee Address	Date of Hire	Campus AgCenter	
Spouse's Name	Spouse's Date of Birth	Annual Salary	

LIFE COVERAGE SELECTION										
<p>Employee Life: Up to three (3) times salary Guaranteed Issue in increments of \$10,000, not to exceed a maximum of \$500,000. Once covered, employees may increase coverage amounts by \$10,000 per year during open enrollment on a Guaranteed Issue basis up to the individual coverage limit.</p> <p>Spouse Life: Once employee enrolls, up to \$10,000 Guaranteed Issue in increments of \$5,000. Additional coverage up to 1/2 of the employee's life coverage is available in \$5,000 increments, but is subject to Evidence of Insurability.</p> <p>Child(ren): Children ages 14 days to 6 months of age are covered for \$1,000 if selected. Check a coverage option below.</p>										
Age	Employee Rate / \$10,000	Spouse Rate / \$5,000	Coverage Selection				Premium Calculation			
<25	\$0.60	\$0.38	Life	Coverage	=	# Units	X	Rate	=	Mo. Amount
25-29	\$0.70	\$0.45	Employee	\$	=	\$10,000	X		=	
30-34	\$0.80	\$0.50	Spouse	\$	=	\$5,000	X		=	
35-39	\$1.00	\$0.63	Child(ren)	<input type="checkbox"/> \$5,000 for each eligible dependent child \$1.00/mo. <input type="checkbox"/> \$10,000 for each eligible dependent child \$2.00/mo.						
40-44	\$1.20	\$0.75	AD&D Coverage: Amount equal to life insurance coverage							
45-49	\$1.70	\$1.05	Employee	\$	=	\$10,000	X	\$0.40	=	
50-54	\$2.90	\$1.80	Spouse	\$	=	\$5,000	X	\$0.20	=	
55-59	\$4.70	\$2.95								
60-64	\$7.30	\$4.75								
65-69	\$14.10	\$8.80								
70+	\$22.80	\$14.25								

BENEFICIARY INFORMATION <i>Designate your beneficiary(ies) below</i>			
Primary Beneficiary(ies)			
Name of Beneficiary (last name, first, mi)	SSN	Relationship	Benefit %
_____	_____	_____	_____
_____	_____	_____	_____
Contingent Beneficiary(ies)			
Name of Beneficiary (last name, first, mi)	SSN	Relationship	Benefit %
_____	_____	_____	_____
_____	_____	_____	_____

READ THIS INFORMATION CAREFULLY AND THEN SIGN, COMPLETE SS# AND DATE BELOW ▼

- I authorized my employer to deduct from my wages the premium, if any, for the elected coverage.
- To the best of my knowledge and belief, the information I have provided on this form is correct.
- **I understand that any person who knowingly presents a false or fraudulent claim for payment of loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**
- I understand my coverage begins on the effective date assigned by ReliaStar Life, provided I am actively at work.
- I also understand that evidence of insurability may be required for coverage to become effective.

Employee's Signature	Date Signed
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For office use	
Pay type	
Monthly deduct	
Effective date	

Return completed form to your HRM office.

The employee is the beneficiary for any spouse or child(ren) insurance coverage.

Underwritten by ReliaStar Life Insurance Company, policy form LP00GP. Rates shown are guaranteed until 7/1/2007.