Financial Protection
ENROLLMENT/CHANGE FORM

Check the box for the Financial Proection benefit(s) you would like to enroll in or make changes to. All Employee and applicable Dependent sections must be completely filled out in the event you are making changes. Descriptions of each Plan can be found on your HR's website or in the Benefits Book. Contact your local HR/Benefit Staff for additional information.

FOR OFFICE USE ONLY (All fields are REQUIRED)

Effective Date of Change: ____________________
HR/Payroll Rep: ____________________
Pay Type: ____________________
Campus: ____________________
Date Event Occurred: ____________________

TYPE OF CHANGE (REQUIRED)

○ Birth/Adoption	○ New Hire	○ Death
○ Marriage	○ Emp Status	○ Divorce
○ Retirement	○ Termination	○ Add/Delete Dependent
○ Cancellation	○ Demographic Change	○ Other ____________

Last Name	First Name	MI	Date of Birth	Social Security #
Mailing Address			City	State / Zip Code
Gender	Home Phone	Work Phone	Email Address	
	Hire date	Marital date	Retirement date	

		Last Name	First Name	MI	SSN	Gender	DOB
☐ Add ☐ Delete	**SPOUSE**						
☐ Add ☐ Delete	**DEPENDENT**						
☐ Add ☐ Delete	**DEPENDENT**						
☐ Add ☐ Delete	**DEPENDENT**						
☐ Add ☐ Delete	**DEPENDENT**						

VOLUNTARY LIFE

Employee	☐ $____________ **Total coverage** (must be in $10,000 increments)			
Spouse	☐ $____________ **Total coverage** (must be in $5,000 increments, not to exceed 50% of employee coverage)			
Child(ren)*	☐ $5,000 ($0.35/month)	☐ $10,000 ($0.70/month)	☐ $15,000 ($1.05/month)	☐ $20,000 ($1.40/month)
Optional AD&D	Coverage Amount must be equal to life insurance coverage			
$0.31/per $10,000	☐ Employee Only	☐ Employee + Spouse	Employee + Child(ren)	Family

☐ **I am enrolling in Life coverage** ☐ **I am cancelling Life coverage** ☐ **I do not wish to enroll**

CRITICAL ILLNESS

	Employee Only	Employee/Spouse	Child(ren)
Low Option	☐ $10,000	☐ $10,000/$5,000	☐ I would like to add $2,500 of child coverage for $0.56/month
High Option	☐ $20,000	☐ $20,000/$10,000	

☐ **I am enrolling in CI coverage** ☐ **I am cancelling CI coverage** ☐ **I do not wish to enroll**

ACCIDENT

Level of Coverage	**Employee Only**	**Employee + Spouse**	**Employee + Child(ren)**	**Family**
Premium	☐ $9.15	☐ $13.60	☐ $12.36	☐ $16.81

☐ **I am enrolling in Accident coverage** ☐ **I am cancelling Accident coverage** ☐ **I do not wish to enroll**

LTD

Long Term Disability Calculation—$__________ Monthly Salary x rate $0.00482 = $__________ Monthly Premium

☐ **I am enrolling in LTD coverage** ☐ **I am cancelling LTD coverage** ☐ **I do not wish to enroll**

AD&D

☐ Employee	☐ $27,500 ($0.83/$1.24)	☐ $55,000 ($1.65/$2.48)	☐ $82,500 ($2.48/$3.71)	☐ $110,000 ($3.30/$4.95)
☐ Family	☐ $165,000 ($4.95/$7.43)	☐ $220,000 ($6.60/$9.90)	☐ $275,000 ($8.25/$12.38)	☐ $300,000 ($9.00/$13.50)

☐ **I am enrolling in AD&D coverage** ☐ **I am cancelling AD&D coverage** ☐ **I do not wish to enroll**

Financial Protection Enrollment/Change Form

Voluntary Life

Age Bands	Rates per $5,000	Rates per $10,000
24 and under	$0.16	$0.32
25-29	$0.20	$0.39
30-34	$0.23	$0.45
35-39	$0.29	$0.57
40-44	$0.36	$0.71
45-49	$0.50	$1.00
50-54	$0.85	$1.70
55-59	$1.30	$2.60
60-64	$1.97	$3.94
65-69	$3.25	$6.50
70-74	$6.12	$12.23
75-79	$10.23	$20.46
80 and older	$18.17	$36.33
EE rates based on EE age Spouse rates based on Spouse age		

Critical Illness

Age Bands	Rates per $5,000	Rates per $10,000
24 and under	$1.85	$3.70
25-29	$2.92	$5.84
30-34	$3.65	$7.29
35-39	$4.89	$9.77
40-44	$6.90	$13.80
45-49	$9.87	$19.74
50-54	$13.79	$27.58
55-59	$19.03	$38.05
60-64	$26.42	$52.83
65-69	$35.45	$70.90
70-74	$49.31	$98.62
75-79	$62.72	$125.44
80 and older	$62.72	$125.44
EE rates based on EE age Spouse rates based on EE age		

Last Name	First Name	MI
Mailing Address		
City	State	Zip
SSN	Birth Date	

VOLUNTARY LIFE

Primary Beneficiary Name(s)	Relationship	% of Benefit
Contingent Beneficiary Name(s)	**Relationship**	**% of Benefit**

CRITICAL ILLNESS

Primary Beneficiary Name(s)	Relationship	% of Benefit
Contingent Beneficiary Name(s)	**Relationship**	**% of Benefit**

ACCIDENT

Primary Beneficiary Name(s)	Relationship	% of Benefit
Contingent Beneficiary Name(s)	**Relationship**	**% of Benefit**

AD&D

Primary Beneficiary Name(s)	Relationship	% of Benefit
Contingent Beneficiary Name(s)	**Relationship**	**% of Benefit**

I authorize my employer to deduct from my wages the premiums, 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 persons who knowingly present a false or fraudulent claim for payment of loss or benefit or knowingly present false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Employee Signature: ______________________________ Date: ______________________