

ENROLLMENT FORM

VOLUNTARY EMPLOYEE AND
DEPENDENT LIFE INSURANCE



VOLUNTARY LIFE ENROLLMENT INFORMATION				
Enrollment Type	<input type="checkbox"/> First Application <input type="checkbox"/> Add Dependents <input type="checkbox"/> Delete Dependents <input type="checkbox"/> Delete All Coverages <input type="checkbox"/> Life Status Change (Marriage Date: _____ Or Birth of Child Date: _____) <input type="checkbox"/> Increase Coverage <input type="checkbox"/> Decrease Coverage <input type="checkbox"/> Other Change: <input type="checkbox"/> I do not wish to enroll for this coverage at this time. I understand that if I should later decide to enroll, all coverage amounts will be subject to satisfactory evidence of good health. (Please skip to the end of this form and sign and date the Declination of Coverage section.)			
Employee	Employer Name University of Iowa Community Medical Services		Group Number 20176039	
	Employee Name (Last, First, Middle Initial)		Date of Birth	Gender
	Occupation		Hours Worked per Week	
	Basic Annual Earnings		Social Security Number	Date of Hire
	Employee's Home Address		City	State
	For MGS Use Only Eff Date:		Status: <input type="checkbox"/> GI <input type="checkbox"/> Underwriting	Emp: _____ K Sp: _____ K Ch: _____ K
Benefit Amount	Please select one of the following: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$90,000 <input type="checkbox"/> \$130,000 <input type="checkbox"/> \$250,000 <input type="checkbox"/> \$450,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$60,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$140,000 <input type="checkbox"/> \$300,000 <input type="checkbox"/> \$500,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$70,000 <input type="checkbox"/> \$110,000 <input type="checkbox"/> \$150,000 <input type="checkbox"/> \$350,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$80,000 <input type="checkbox"/> \$120,000 <input type="checkbox"/> \$200,000 <input type="checkbox"/> \$400,000 Note: Coverage may not exceed 5 times the Employee's Basic Annual Earnings.			
Guaranteed Issue Amount	The Guaranteed Issue amount is the amount of insurance that you may elect within 31 days of becoming eligible. The Guaranteed Issue amount is up to \$150,000 for physicians and all other designated employees. The spouse Guaranteed Issue amount is \$30,000. If you enroll after this period, evidence of good health will be required for all coverage amounts.			
Dependent Coverage	You may also elect coverage on the lives of your spouse and/or dependent children. To qualify, children must be unmarried and at least 14 days old but less than 21 years (25 years if a full-time student). Medical evidence of good health will not be required for your spouse unless you or your spouse are a late enrollee or your spouse coverage exceeds the Spouse Guaranteed Issue amount. Dependent coverage is available only when you elect coverage for yourself. Dependents may not be covered under more than one employee and an employee may not be also covered as a dependent. If your spouse or dependent child is confined in a hospital or elsewhere because of disability on the date his or her insurance would normally have become effective, coverage (or an increase in coverage) will be deferred until that dependent is no longer confined and has performed all the normal activities of a healthy person of the same age for at least 15 consecutive days. Spouse Benefit Amount: \$ _____ Available in increments of \$1,000 to a maximum of \$250,000, not to exceed 50% of the employee's amount. You may not elect coverage for your spouse if your spouse is covered as an employee under this policy. The spouse Guaranteed Issue amount is \$30,000. The employee is the beneficiary of the Spouse Benefit Amount, unless the spouse designates his or her own beneficiary. Child Benefit Amount: <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 <input type="checkbox"/> None per child Children ages 14 days to 6 months are limited to a benefit of \$100. All Child Benefit Amounts are Guaranteed Issue. The employee is the beneficiary of the Child Benefit Amount.			

VOLUNTARY LIFE ENROLLMENT INFORMATION, CONTINUED

Rates <i>(Premiums may change at any time without prior notice)</i>	The employee's premium is based on the age of the employee on the first of the month that premiums are due. The spouse's premium is based on his or her age on the first of the month that premiums are due. The premiums for both are listed below per \$10,000 of coverage:					
	Under Age 30	\$.70	Age 50-54	\$5.50	Age 75-79	\$101.70
	Age 30-34	\$.90	Age 55-59	\$10.00	Age 80-84	\$159.30
	Age 35-39	\$1.40	Age 60-64	\$15.00	Age 85-89	\$251.40
	Age 40-44	\$2.30	Age 65-69	\$22.40	Age 90-94	\$458.90
	Age 45-49	\$3.50	Age 70-74	\$38.50	Age 95+	\$509.00
	Child(ren) rates are \$.50 per \$2,500 regardless of the number of children covered.					
Benefit Reductions	Coverage amounts in effect prior to age 70 will be reduced by 50% at age 70.					

EMPLOYEE BENEFICIARY INFORMATION

Employee Name			Spouse Name		
Date of Birth	Gender		Date of Birth	Gender	
Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No			Are you actively at work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I am not employed, but perform activities of a person of like age and gender.		
PRIMARY BENEFICIARY	SSN	% OF BENEFIT	PRIMARY BENEFICIARY	SSN	% OF BENEFIT
ADDRESS	DATE OF BIRTH	RELATIONSHIP	ADDRESS	DATE OF BIRTH	RELATIONSHIP
PRIMARY BENEFICIARY	SSN	% OF BENEFIT	PRIMARY BENEFICIARY	SSN	% OF BENEFIT
ADDRESS	DATE OF BIRTH	RELATIONSHIP	ADDRESS	DATE OF BIRTH	RELATIONSHIP
PRIMARY BENEFICIARY	SSN	% OF BENEFIT	PRIMARY BENEFICIARY	SSN	% OF BENEFIT
ADDRESS	DATE OF BIRTH	RELATIONSHIP	ADDRESS	DATE OF BIRTH	RELATIONSHIP
PRIMARY BENEFICIARY	SSN	% OF BENEFIT	PRIMARY BENEFICIARY	SSN	% OF BENEFIT
ADDRESS	DATE OF BIRTH	RELATIONSHIP	ADDRESS	DATE OF BIRTH	RELATIONSHIP

If you name more than one beneficiary with unequal shares, please show the percentage of the insurance benefit to be paid to each beneficiary. For example: 33-1/3% to Mary Jones, mother and 66-2/3% to Edith Jones, wife.
A beneficiary may be changed at any time upon written request.

I hereby designate a beneficiary under the terms of my employer's Voluntary Term Life Insurance policy and authorize my employer to make the appropriate payroll deductions for the coverages I have specified above. I represent that the statements above are true and complete to the best of my knowledge and belief and are binding on any person claiming an interest in the coverage issued. Employee Signature: _____ Date: _____	I hereby designate a beneficiary under the terms of my spouse's Voluntary Term Life Insurance policy as indicated above. If no signature appears I understand that my beneficiary will be my spouse in accordance with the terms of the policy. Spouse Signature: _____ Date: _____
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DECLINATION OF COVERAGE

I elect to decline coverage at this time.
Employee Signature: _____ Date: _____

Please return completed form to:
Medical Group Insurance Services, P.O. Box 16110, 1849 West North Temple, Salt Lake City, UT 84116

This Enrollment Form explains the general purposes of the insurance described, but in no way changes or affects the policy as actually issued. In the event of any discrepancy between this document and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read the certificate of insurance booklet carefully and keep it with your important papers.