

Mark all boxes and complete all sections that apply. Return completed from to your Human Resources Department.

**Life with AD&D Employer Paid**

EMPLOYEE	Your name (Last, First, Middle)		Group Name <b>County of Imperial</b>	Group Number <b>643603</b>	
	Your Address		City	State	ZIP
	Your Soc. Sec. No.	Date of Birth	Male / Female	Job Title/Occupation	
BENEFICIARY	<i>This designation applies to life/Life with AD&amp;D Insurance available through County of Imperial. Design actions are not valid unless signed, dated, and delivered to the County of Imperial during your lifetime. See page 2 for further information.</i>				
	Primary – Full Name		Address	Soc. Sec. No	Relationship % of Benefit
CHANGE	<b>Use this section only when you wish to make a change after insurance becomes effective. Complete all boxes and sections that apply.</b>				
	<input type="checkbox"/> Beneficiary Change		<input type="checkbox"/> Cancellation		Effective Date _____

**Additional/Optional Life** To elect additional life insurance, complete sections below.

ADDITIONAL LIFE	Check with your Human Resources Department about coverage options available to you and Evidence of Insurability requirements. <b>Additional/Optional Life</b>				
	<input type="checkbox"/> Additional/Optional Life Your Requested Amount \$ _____ To calculate your premium: $\frac{\text{Amount Elected}}{\$10,000} = \text{_____} \times \frac{\text{Rate}}{\text{(from column 1 on page 2)}} =$				\$ _____ Your biweekly cost
DEPENDENTS LIFE	<input type="checkbox"/> Spouse requested amount \$ _____ Spouse Name _____ Date of Birth _____ To calculate your premium: $\frac{\text{Amount Elected}}{\$10,000} = \text{_____} \times \frac{\text{Rate}}{\text{(from column 2 on page 2)}} =$				\$ _____ Your biweekly cost
	<input type="checkbox"/> Children requested amount \$ _____ To calculate your premium: $\frac{\text{Amount Elected}}{\$2,000} = \text{_____} \times \frac{0.28}{\text{Rate}^*} =$				\$ _____ Your biweekly cost
	* Child(ren) Biweekly rate is \$0.28 per \$2,000 of coverage, regardless of the number of children covered under the plan.				
<b>Total biweekly cost:</b>					\$ _____

SIGNATURE	I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deductions amount will change if my coverage or costs change.	
	Member/Employee Signature Required	Date (Mo/Day/Yr)

## Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies)
- If you name two or more Beneficiaries in a class:
  - Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  - If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary (ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage of fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  - If only Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For Example, "Dorothy Q. Smith, Trustee under the trust agreement dated \_\_\_\_\_."
- A power of attorney must grant specific authority, by the terms of the document of applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

### Additional Life Insurance Rates

	<b>Column 1: Employee Rate</b>	<b>Column 2: Spouse Rate</b>
<u>Age on Prior January</u>	<u>(Per \$10,000 of Total Coverage)</u>	<u>Rate (Per \$10,000 of Total Coverage)</u>
<29	\$0.44	\$0.40
30-34	\$0.66	\$0.57
35-39	\$0.77	\$0.63
40-44	\$1.10	\$0.99
45-49	\$1.87	\$1.61
50-54	\$3.10	\$2.68
55-59	\$4.61	\$3.92
60-64	\$7.44	\$5.95
65 & Over	\$9.82	\$8.43

**Human Resources Department – Complete this section. Retain form for your records.**

Division ID	Billing Category	Date of Hire or Rehire	Hours Worked per Week	Earnings \$ _____ Per: <input type="checkbox"/> Hour <input type="checkbox"/> WK <input type="checkbox"/> Mo <input type="checkbox"/> Yr.
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