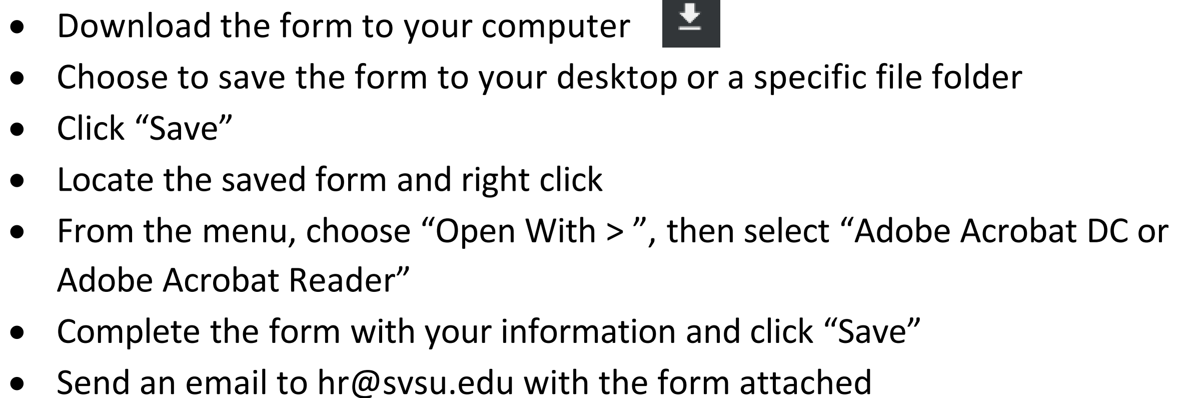
Please see next page for the Adobe Fillable Form

Directions for Completing & Submitting:

If the form opens in a web browser users need to download and save the file. Do not fill it out or print from the browser.



- Download the form to your computer
- Choose to save the form to your desktop or a specific file folder
- Click “Save”
- Locate the saved form and right click
- From the menu, choose “Open With > ”, then select “Adobe Acrobat DC or Adobe Acrobat Reader”
- Complete the form with your information and click “Save”
- Send an email to hr@svsu.edu with the form attached

*To download adobe or if you need additional assistance, please visit the Knowledge Article - Completing Fillable Forms section.

SAGINAW VALLEY STATE UNIVERSITY

Group Life and Supplemental Life Insurance Enrollment and Change Form

UNUM LIFE INSURANCE COMPANY OF AMERICA

Name:	______________________________	***Last Four of SSN #:***	______________________________
Date of Birth:	____________________	***Effective Date:***	______________________________
Hire Date:	____________ **Age:**________	***Annual Salary:***	______________________________
			New Hire **Life Event** **Open Enrollment**

Group Life Insurance - Employee

Saginaw Valley State University provides you with **employer paid** life insurance.

Non-Medical Maximum

Employees whose base salary is less than $50,000 will receive: 4x annual salary to $500,000
Employee whose base salary is $50,000* or more will receive: 3x annual salary to $500,000

3x Annual Earnings or $200,000

You also have the option to decrease your employer paid life insurance to $50,000 to avoid paying taxes on coverage above $50,000.

☐ I elect $50,000 in Employer Paid Life insurance and decline the three or four times salary benefits that is available to me. I understand that if I wish to change my election at a future annual enrollment, I will be considered a late enrollee. As a late enrollee, I will be required to provide evidence of good health that is satisfactory to UNUM Life and understand my request for coverage may be denied. If a physical is required, I will be responsible for its cost. Your AD&D benefit is equal to your life benefit.

At no time can your total employer paid life insurance exceed the $500,000. Please use the Premium Chart and calculation lines below to determine your **monthly cost** for this coverage. Costs should be calculated based on your age as of your effective date of coverage.

Supplemental Life Insurance - Employee

Employee Age	< 24	25 -29	30 -34	35-39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64	65 - 69	70 -74	75+
Rate	$0.052	$0.052	$0.068	$0.081	$0.099	$0.153	$0.27	$0.45	$0.612	$1.188	$2.277	$4.086

☐ I elect to **enroll** in the Supplemental Life plan in the amount of: ☐ one times salary ☐ two times salary ☐ three times salary ☐ four times salary or ☐ five times salary not to exceed $500,000. Please refer to **Premium Chart** to determine the correct rate.

$__________	x	$__________	=	$__________	÷ $1,000 =	$__________	x	$__________	=	$__________
Annual Salary		Elected Multiplier 1, 2, 3, 4 or 5 Times Salary		Elected Benefit Amount (rounded to next higher $1,000)		The maximum allowed is $500,000		Rate from Premium Chart		Your Monthly Cost

☐ I elect to **decline** the Supplemental Life plan. ☐ I elect to cancel current coverage.

Supplemental Life Insurance - Spouse

You may elect Supplemental Life coverage for your Spouse in the amount of $10,000, $25,000, $50,000 or $100,000. If you elect an amount that exceeds the **guaranteed issue amount of $50,000**, your spouse will need to provide evidence of good health that is satisfactory to UNUM Life before the excess can become effective. Please use the Premium Chart below to determine your **monthly cost** for this coverage. ***Note: Premium costs are based on your (the spouse's) age. The employee is automatically the beneficiary for this coverage.***

Spouse Age	< 24	25 -29	30 -34	35-39	40 - 44	45 - 49	50 - 54	55 – 59	60 - 64	65 - 69	70 -74	75+
$10,000	$0.52	$0.52	$0.68	$0.81	$0.99	$1.53	$2.70	$4.50	$6.12	$11.88	$22.77	$40.86
$25,000	$1.30	$1.30	$1.70	$2.03	$2.48	$3.83	$6.75	$11.25	$15.30	$29.70	$59.93	$102.15
$50,000	$2.60	$2.60	$3.40	$4.05	$4.95	$7.65	$13.50	$22.50	$30.60	$59.40	$113.85	$204.30
$100,000	$5.20	$5.20	$6.80	$8.10	$9.90	$15.30	$27.00	$45.00	$61.20	$118.80	$227.70	$408.80

☐ I elect to **enroll** my spouse in the Supplemental Life plan for $________________________ at the monthly cost of $_____________.

Spouse's Date of Birth ___ - ___ - _____ ☐ I elect to **decline** coverage ☐ I elect to cancel coverage

*Note: Benefit reductions for Employee and Spouse begin at Employee age 70. Please see your benefits administrator for further information.

Supplemental Life Insurance - Child(ren)

You may elect Supplemental Life coverage for your Dependent Child(ren) between the ages of 6 months and the end of the calendar year in which your child turns 26 in the amount of $5,000 or $10,000. The rate is the same regardless of the number of children covered. **The employee is automatically the beneficiary for this coverage.**

Child(ren)Life Amount	$5,000	$10,000
Cost	$0.18	$0.36

☐ I elect to **enroll** my child(ren) in the Supplemental Life plan for $_________________________ at the monthly cost of $____________.

☐ I elect to **decline** the Supplemental Life plan for my dependent child(ren). ☐ I elect to cancel current coverage.

Note: Children from birth to 6 months of age are limited to coverage in the amount of $1,000.

Beneficiary Designation

It is important that your beneficiary designation be clear so that there will be no question as to your meaning. It is also important that you name a primary and contingent beneficiary. When naming your beneficiary(ies) please indicate their full name, address, social security number, relationship, date of birth and distribution percentage. If the beneficiary is not related either by blood or by marriage, insert the words, "Not Related" next to their stated relationship. If you need assistance, contact your benefits administrator or your own legal counsel. Following are examples of the most common designations:

Primary:

- Mary J. Doe, Wife (not Mrs. John Doe).

Contingent:

- Joseph W. Doe, Son and Jane Doe, Daughter, in equal shares (50%).
- Estate of the Insured.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in fractional parts, for example "33% to Mary Jones, Mother, and 67% to Edith Jones, Wife."

Primary – Full Name	Address	Last Four of SSN #	Relationship	D.O.B.	%
Contingent – Full Name	Address	Last Four of SSN #	Relationship	D.O.B.	%

The beneficiary for life insurance on the lives of your spouse and children will automatically be you, if surviving, otherwise the estate of the spouse and children, subject to policy provisions. A beneficiary for employee Life Insurance may be changed upon written request.
If you want a different beneficiary for the 1 or 2 times to be different than the group life, complete two individual forms.

Employee Confirmation

I have been given the opportunity to enroll in Saginaw Valley State University's Supplemental Life Insurance plan. I understand if I do not enroll when initially eligible, but later decide to enroll or increase my supplemental life amount, I will be considered a late enrollee. As a late enrollee, I will be required to provide evidence of good health for myself and/or my spouse that is satisfactory to UNUM Life Insurance Company of America and understand my request for coverage may be denied. If a physical is required, I will be responsible for its cost. I understand that this plan requires a minimum participation of 25% to remain in-force.

I authorize my employer to make the appropriate payroll deductions from my wages on a post-tax basis. I am not now disabled and I am performing all the duties of my occupation on a full-time basis. All dependents on which I am electing coverage are not currently disabled and are performing all activities of daily living.

Signature: ____ **Date:** ___________________________

EMPLOYEE MUST RETAIN A COPY OF THIS FORM FOR CLAIM PURPOSES

PLEASE SIGN AND RETURN THIS FORM TO HUMAN RESOURCES